

CA20N

Z 1

-80A0 21

GOVT PUBNS



ROYAL COMMISSION ON MATTERS OF HEALTH AND SAFETY
ARISING FROM THE USE OF ASBESTOS IN ONTARIO

CHAIRMAN: J. STEFAN DUPRE, Ph.D.

COMMISSIONERS: FRASER J. MUSTARD, M.D.
ROBERT UFFEN, Ph.D., P.Eng., F.R.S.C.

COUNSEL: JOHN I. LASKIN, LL.B.

APPEARANCES:

Mr. D. Starkman
Mr. N. McCombie
Miss L. Jolley

Asbestos Victims of Ontario
Injured Workers Consultants
Ontario Federation of Labour

180 Dundas Street
Toronto, Ontario
Wednesday,
July 14, 1982
VOLUME 49



Digitized by the Internet Archive
in 2023 with funding from
University of Toronto

<https://archive.org/details/31761116497207>

ROYAL COMMISSION ON MATTERS OF HEALTH AND SAFETY

ARISING FROM THE USE OF ASBESTOS IN ONTARIO

VOLUME 49

INDEX OF WITNESSES:

DR. ALEXANDER CHARLES RITCHIE	Examination-in-chief	Page	3
	Cross-examination (Starkman)	Page	76
	Cross-examination (McCombie)	Page	83
	Cross-examination (Jolley)	Page	92
MR. JOHN McDONALD	Cross-examination (Starkman)	Page	100
	Cross-examination (Jolley)	Page	121
	Exam-in-chief (cont'd.)	Page	128

180 Dundas Street
Toronto, Ontario
Wednesday,
July 14, 1982

180 Dundas Street
Toronto, Ontario
Wednesday,
July 14, 1982

VOLUME 49

THE FURTHER PROCEEDINGS OF THIS INQUIRY
RESUMED PURSUANT TO ADJOURNMENT

APPEARANCES AS HERETOFORE NOTED

DR. DUPRE: Good morning, ladies and gentlemen.
This morning we warmly welcome Dr. Alexander
Ritchie, professor of pathology at the University of Toronto.
Dr. Ritchie, may I please ask you, sir, to come
forward and be sworn?

DR. ALEXANDER CHARLES RITCHIE, SWORN
EXAMINATION-IN-CHIEF BY MR. LASKIN

Q. Dr. Ritchie, could you tell us your present
professional position?

A. Yes. I am a professor of pathology in the
University of Toronto, a senior pathologist at the Toronto General
Hospital, consultant to various other hospitals, and I take it
that's enough.

Q. Thank you.
Could you, just very briefly for us, sketch your
educational background and professional qualifications?

A. Yes. I graduated in medicine in New Zealand in
1944. After spending two years in hospital there, I went to

5 A. (cont'd.) England, where I was in Oxford, concerned largely with experimental work, until 1951, I think, when I went to Chicago and again continued in the experimental field, then went to Boston and reverted to diagnostic pathology.

After that, I was in McGill for, I think, seven years, in the department of pathology, and then came to Toronto as head of the department here, and have remained in Toronto ever since.

10 Q. Have you had any, in terms of your pathology, have you had a particular interest in or particular training in industrial diseases?

15 A. How shall I say? In passing, in that when I came to Toronto, very soon after I came to Toronto - I forget when - I was asked by Dr. Cole, who was at that time here, to look at the pathological material from all industrial cases coming before the board, and have done so since that time.

Q. And have retained, therefore, your interest in and study of those diseases?

20 A. Yes, getting steadily more elaborated as time went by, and it was necessary both to elaborate the pathological examinations adequately to meet the case, and of course getting more and more entrammelled in the interests of the subject.

25 Q. Can we, first of all, just enumerate the ways in which you have had an association with the Workmen's Compensation Board, and as I understand it, first of all you have had a role in the formulation of certain guidelines for the compensation of asbestos-related diseases?

A. Yes. Yes.

30 Q. Secondly, as I understand it, you have acted and indeed continued to act as a consultant to the Board, through the medical services division?

A. Yes.

Q. Finally, as I understand it, you have in the past

5 Q. (cont'd.) had some liaison with the advisory committee on occupational chest disease in that you attended certain of their meetings and discussed certain of their cases with them?

A. Well, only very occasionally and very informally.

10 Q. As I understand it, those informal and occasional discussions took place in the past, but in the last few years have not taken place?

A. It was some years, I would think, since we last met in any sense.

15 I should say these meetings with the Board were rather concerned with their understanding of what I wrote, and my comprehension of what would be useful to the Board for me to express explicitly. They were not concerned with evaluation of anybody or any claim, but rather the communication of a principle.

Q. When you say the Board, I take it you mean the advisory committee?

20 A. I mean the Board, including the advisory committee.

Q. All right. Well, we'll come back to that.

Can we take those three areas in which you have interacted with the Board and go through them, and can we start first of all with your role in formulating certain guidelines for the compensation of asbestos-related disease?

25 A. Yes. This was initiated by the Board, expressed by Dr. Stewart, who was the letter writer for the Board, who asked me to review the evidence on the various questions that were raised - for example the role of asbestos in causing disease.

30 What I did was to review the literature available on this subject at that time, assess it and express my opinion as to the various points that were established, in doubt, not established and so on.

5 A. (cont'd.) In particular the question was, of course, the role of asbestos in causing various types of disease, and hence the opinions were my conclusion as to the state of knowledge on those matters - the relation of asbestos to asbestosis, to carcinoma, to mesothelioma and so on.

Now, having completed this review of the literature, I wrote the reports which you have no doubt seen...

10 Q. Yes.

A. ...and transmitted this to the Board, again through Dr. Stewart.

Q. Looking at the reports, I take it in fact there were three of them?

A. There were three on asbestos, yes.

15 Q. Did you in fact then do reports on other substances than asbestos?

A. Yes. Recently the Board asked me if I would look into the evidence that there was an increased risk of carcinoma in welders, which I'm glad to say is a much smaller project than asbestos, and indeed acted in a similar fashion. Dr. Stewart conveyed the Board's request to investigate this matter, and again I looked through the literature and drew such conclusions as seemed proper.

20 Q. In relation to asbestos were you specifically requested to render an opinion on what would be appropriate criteria for compensating an employee who was exposed to asbestos, or may have been exposed and contracted a particular disease?

25 A. It's some time since I did this, and just what the terms of that letter were, I don't remember. The request certainly was rather more on a medical opinion than strictly related to compensation. Compensation question, of course, flows obviously from the medical side, but I addressed myself rather to 'does asbestos cause carcinoma of the lung', shall we say, and if so, under

30

A. (cont'd.) what conditions, and to some degree, how. Of course, there is very little known as to the 'how' part of it.

5 Q. You reviewed whatever literature there was in the world, I take it?

A. So far as I could.

Q. And I take it there were no independent studies conducted in connection with this? It was essentially a literature review?

10 A. Yes. It was a literature review and the answers that you can get from such a review, I think, need to be divided into three groups.

15 So far as, say, the relation between asbestos and mesothelioma, the evidence is so overwhelming that there is no doubt that asbestos can cause mesothelioma, and this is a very simple question which I think is beyond belief. It stands very clearly from the literature.

20 You can equally imagine that on reading the literature one could discover that asbestos had no relation whatsoever, shall I say, to...well, there was no evidence that asbestos had any relation, say to acute appendicitis, or some utterly unrelated condition, which would be a clear negative.

25 Now, there are, then, the conditions that come in between, and the most prominent of these, of course, was the relation between asbestos and carcinomas of the gastrointestinal tract. Here there is considerable body of evidence suggesting that these carcinomata are in fact more common in people exposed to asbestos. But equally, the excess was not so great that it is indeed self-evident, and in this case I did not think that my knowledge was sufficient to assess properly the literature in this area, and as you know, I therefore suggested that an epidemiologist be asked to assess it from that aspect, and indeed the Board
30 requested Dr. Miller to make that assessment.

5 A. (cont'd.) So I think the kind of review that I did for these things can have three answers. There can be a clear positive, there can be a clear negative, or it can fall in between and you may then need further study.

Indeed, in the case of carcinoma of the larynx and asbestos, Dr. Miller actually carried out his own study to try and solve the question of the relationship there.

10 Q. Having prepared your report, did you, before submitting it to the Board, discuss it with anyone else in your field?

15 A. Not at any great length. I should say there is almost nobody with whom I could discuss it, whose opinion would be really worth listening to, in that remember this is a very rare condition - asbestos disease is rare. Very few people will ever see one. Very few pathologists are likely ever to come across a case of asbestosis.

Certainly I may have discussed it, and probably did in passing, with all sorts of people, but it is not a thing in which there is a widespread expertise.

20 Q. I think we will all have some questions on the contents of your report, particularly in relation to certain of the conditions, but can I just ask you, since you prepared your report have you been called upon to re-evaluate it or reconsider the criteria that you proposed?

25 A. Well, it did have...the report, the first report on asbestos did have the two supplements that the Board requested me to prepare.

Q. And I take it the last supplement, as I recall, was delivered to the Board in 1976?

A. It would be something like that, yes.

30 Q. Have you been called upon by the Board since 1976, to look at the subject again?

A. No.

Q. Okay.

5 A. I should say nor do I see any particular reason to do so. Clearly at some time it should be reviewed, but I would not have thought that there was a good reason to review it now.

Q. Why do you say that?

10 A. Because I am not aware of any evidence that would cause me to change, essentially, the opinions I had at that time.

Q. At that time.

15 Q. Can I just ask you a few questions about some of the substantial content of your reports, and first of all dealing with mesothelioma and you have just given your evidence, as far as you were concerned, that the relationship between asbestos and mesothelioma was something beyond dispute, and indeed as I read your recommendation it was that all, with any exposure to asbestos, who develop mesothelioma, should be compensated?

A. Yes.

20 Q. And I take from what you have said that's still your view?

25 A. Yes. Mind you, it does have that qualification - I do not think that all who get mesothelioma should be compensated. If somebody has no exposure, no history of exposure to asbestos, no evidence of asbestos fibers in the lung in unusual quantity, then I do not think there is any case for thinking that particular patient had an asbestos-induced mesotheliomata.

A mesothelioma, though certainly the vast majority of mesothelioma patients do have asbestos exposure.

30 DR. UFFEN: Could I just get this clear? We have been told by other witnesses that all mesotheliomas were due to asbestos. I gather from what you have just said that you wouldn't agree to that, that many or a large part, but not all?

THE WITNESS: I think medically speaking 'all' is

THE WITNESS: (cont'd.) always wrong...if you can
pardon me breaking my own rule in my own statement.

There is no evidence that all mesotheliomas are
produced, caused by asbestos. There is certainly very good
evidence that a very great majority probably of them are the result
of exposure to asbestos, but there are people known who have no
history of asbestos exposure, no evidence of asbestos involvement
in the lung, and mesothelioma.

One is always left, of course, with the question of
the adequacy of the investigation in these patients. That's not
always clearly evident from the reports.

But I would say most, but not all.

MR. LASKIN: Q. Are you familiar with the guideline
that was actually adopted by the Board with respect to mesothelioma?

THE WITNESS: A. In a general fashion, yes.

Q. As I read...

A. Apart from reading Mr. Barth's report.

Q. It requires, as it's terms, a 'clear and adequate
history of at least ten years occupational exposure and a minimum
latency period of fifteen years', and I suppose my question to you
is, do you know why, or the criteria that were actually adopted
by the Board seem to differ from the recommendation that you yourself
made with respect to compensation for mesothelioma?

A. No, I do not know why they differ, nor do I
find those figures unreasonable, since the actual figures to be
set must be an arbitrary matter. And I would certainly interpret
any guidelines of this sort that one would write down, that if a
patient has a mesothelioma, diagnosis being properly established,
and has a history of exposure to asbestos industrially, or has
evidence of asbestos, abnormal asbestos exposure, in the lungs,
then he is compensatable meeting those criteria.

5 A. (cont'd.) I do think, however, that whatever criteria you were to write and whatever rules you might devise, you would always have to consider the people who do not meet them, in that though mesothelioma may be an exception, most tumors you have a relation between most tumors in which we know the cause, you have a relation between the dose of the causative agent which tends to both increase the likelihood of getting tumor as the dose becomes greater, and tends to cause it to appear quicker.

10 There is some evidence that this is not true in mesotheliomata, but if so they are a considerable exception to the general resulting tumors.

15 So having got the criteria that clearly established people as compensatable, I would still look at the othersto see if there was any extraordinary factors such as an enormous exposure to asbestos, or something of this kind, that might cause an exception to be granted for that individual.

20 I don't think any rule can ever encompass everything fairly, unless you make the rule so lax that you allow all sorts of people in who do not deserve compensation.

25 Q. When I looked at the recommendations that you made in respect of mesothelioma, lung cancer, gastrointestinal cancer, what I saw was...and please correct me if I'm wrong...but what I saw was that you suggested that there be evidence of occupational exposure to asbestos in respect of all of them, of course, but in none of them did you suggest any minimum period of exposure.

A. No.

Q. And in respect of mesothelioma, I didn't even find any requirement of latency period, as opposed to lung cancer or GI cancer.

30 A. In one of my reports I think I say that there must be adequate exposure to asbestos, and follow that by a

5 A. (cont'd.) statement that I cannot define
adequate, and I think this is the state of our knowledge at the
moment - you cannot say that it takes X years exposure before you
become susceptible to one of these tumors. You cannot say that it
requires so much asbestos in the lung or such and such a concentration
10 of asbestos in the industrial environment. There is no data to
make such an assessment, so the best one can do is ask that there
be some reasonable exposure to asbestos as shown by some reasonable
measure - either in the tissues or by the patient's history.

Q. Do I put it fairly to suggest to you that if you
were called upon to write criteria yourself, rather than putting
in specific years and so on you would frame your requirements in
terms of, as you put it, reasonable exposure?

15 A. Well, what I wrote...like an earlier character
in history, I wrote. I think medically what I have said is
correct. I do think if you look at the particular point at the
Board, they need a rule which enables them readily to accept
readily-acceptable claims, and it's all very well for me, writing
in a theoretical sense, to say that adequate exposure is required.
20 They have to define that 'adequate', and I don't object to the
rule as created by the Board, provided it is taken to mean that
people who meet it are compensatable, and people who do not meet
it should be considered individually to see whether or not there
are circumstances in their case which would cause them also to
be compensatable.

25 Q. Can we turn to your study of cancer of the
gastrointestinal tract, which I take it from your evidence was
then subsequently backed up by Dr. Miller's epidemiological study?

A. Yes.

30 Q. Have you in front of you, Dr. Ritchie, a copy of
those studies?

A. No, I didn't bring that with me.

Q. Let us put that in front of you and it may be of some assistance.

Can I take you to your supplementary report dated April 15, 1976?

A. I still don't have my own report here. This is your report.

Q. It's appendix three in the WCB submission... page five of appendix three.

A. Page five. Ah, there it is.

Q. Can we come to paragraph A forty-three, which appears to be your conclusion following certain observations from the literature, among which is that there does not appear to be any excess cancer mortality from drinking water with asbestos fibers, and you summarize your conclusions about the excess, and in subsection H say,

"Presumably the increase in carcinoma of the alimentary system is caused by asbestos fibers swallowed, but there is no evidence on this point."

Now, can I, just to put the discussion in context, can I put to you a competing proposition that was advanced to this Commission about four months ago by Professor John Davis from Edinburgh, who appeared before this Commission and gave evidence, and specifically on this point?

As I recollect his proposition, it was that you could indeed find excess cancer mortality from...in the gastrointestinal tract, and indeed his animal experimentation had shown that, and his explanation as to how that happened was not that the fibers got there from swallowing them or ingesting them, but that they got there from inhaling them and then travelling along the lymphatic tract, and that if we are looking at excess mortality in the gastrointestinal tract, we needn't worry about it arising because of drinking or eating asbestos fibers - what we should be

Q. (cont'd.) concerned about is the travel of these fibers through our body after they have been inhaled.

5 Can I...I don't see anything in your conclusions or your observations about Mr. Davis's proposition.

A. I am familiar with his proposition. It seems to me to be singularly improbable, and there are a number of reasons for this.

10 One of the major problems with the relationship between asbestos and cancer of any sort is, we really don't have any sensible explanation...sensible being taken in the context of our explanations of other known experimental cancers.

15 The particular fact which causes trouble is that it does seem true in experimental work and probably in man that the long, thin fibers are the only ones that are dangerous, and it's almost impossible to make any cellularly sensible explanation as to how this might act. The various theories are summarized in the paper that I think Dr. Mustard is looking at, and none of them are impossible, none of them seem very probable.

20 Now, it's not clear, for example, whether the gastrointestinal carcinomas in particular are actually caused by the presence of asbestos fibers, or conceivably by some secondary effect initiated by asbestos, not necessarily in the gastric tract at all. One could, for example, take the view that asbestos fibers stimulate the activation of carcinogens, and then the carcinogen could be carried to the intestinal tract and it could be a carcinogen which happened to have a particular affinity for the gastrointestinal tract. It's quite a possible theory and has been advanced, but you will note the very large numbers of 'could be's' that interlarded that remark.

25
30 So the asbestos need not actually be present in the stomach to be the cause of the gastric carcinoma. This would be one problem.

5 A. (cont'd.) We know, however, that asbestos fibers of appropriate length can be found in the tissues in and around gastrointestinal carcinomata. We have, in fact, identified them in the two cases that we studied here in Ontario, which is a very expensive, difficult and time consuming activity, but it can be done. So we know the fibers are there.

10 We also know the fibers swallowed can penetrate the gastrointestinal wall and can in fact travel considerable distances in the tissues. Very small numbers of them do so, but they do.

If you are going to induce a tumor, presumably you only need one, if you take the ordinary hypothesis.

15 Furthermore, we know that asbestos fibers inhaled into the lungs are, in large proportion, cleared by the... particularly by the mucus elevator in the bronchii, and are then swallowed and normally passed through the gastrointestinal tract and passed in the feces. So the fibers inhaled do in fact go through the gastrointestinal tract, all of which would suggest that it's a perfectly reasonable hypothesis that in some ways the
20 fibers induce the carcinoma of the stomach by damaging the epithelial cell that gave rise to that particular carcinoma.

25 Now, if you want to take them by the lymphatics, you have a very considerable series of problems. First of all, the lymph flow from the stomach to the lung is from the stomach upwards, so you have to imagine these inert fibers somehow swimming against the flow. Normal lymph pattern would not carry anything from the lung to the stomach. The only occasion on which I think it's likely that lymph from the pulmonary region is likely to flow down towards the stomach or the colon, is if you for some reason obstruct the lymph flow in the chest, such as can commonly
30 enough be done in carcinoma of the lung. Then you do get a

A. (cont'd.) reversal of the lymph flow.

5 If that happens, the carcinoma, if you use that as a marker of the spread of the carcinoma, as to where the carcinoma is flowing, the carcinoma spreads to the lymph nodes at the back of the abdominal cavity - not into the intestine at all.

10 So if you put something in the lymph, you wouldn't really expect to find it getting into the gastric or colonic wall, although it's possible.

15 But even if you allow that the fibers could proceed against the normal direction of flow, you must think that if you take the ordinary view that the dangerous fibers are these long, thin spears, you put them in little vessels that are really not much bigger than the spears themselves, and certainly much narrower than the ten mu length of the spear at least when they begin and at least when they end in the little lymphatics...the intermediate ones might be larger channels.

20 Q. Just let me understand that. If we take the ordinary view, as you put it, that the more dangerous fiber is the long, thin fiber - and I take it by that you mean a fiber of ten microns?

A. Five mu or more.

25 Q. And then are you telling us that they, to put in my layman's terms, that they don't fit very easily into the lymphatic tract, and if they do, the fit is so tight that they are likely to get caught somewhere down the line?

30 A. In fact I'll use an analogy. If you imagine taking a spear six feet long and putting it into a pipe that varied from two feet upwards, perhaps imagine a plastic pipe which is not straight, the likelihood of that spear travelling very far in that pipe is not very great before it gets trapped in the wall somewhere.

I find it very hard to think of such a large particle

A. (cont'd.) being carried in the lymph, even if the lymph was going in the right direction.

Perhaps I should say that you do find occasionally asbestos fibers of that length in lymph nodes, where they presumably have gone by the length. But nevertheless, I find the thought of getting them down to the gut a formidable hypothesis.

MR. LASKIN: I'm going to defer to Dr. Mustard.

DR. MUSTARD: Dr. Ritchie has indicated I'm looking at an article by Craighead and Wassman (ph.) in the New England Journal of Medicine of June 17th, 1982.

If I may just...I take you probably have seen this article?

THE WITNESS: I have seen it.

DR. MUSTARD: They make the comment here, just to pursue the lymphatic story a bit further. They state:

"The experimental evidence strongly suggests that ingested asbestos is disseminated through abdominal organs by the lymphatics and blood vessels."

I would take it, if that statement is true, that there must be some capacity at least for the abdominal lymphatics to transport asbestos fibers to at least the lymph nodes. Is that...?

THE WITNESS: I would find that statement surprising. No, I don't doubt they made it. I read it there.

What I didn't get around to is looking up the evidence on which they base it.....since my impression certainly is not in keeping with that conclusion.

DR. MUSTARD: They make a second statement which, if I may ask, which is pertinent to this, which I also find intriguing. It's in relation to ingested water, and water supplies.

They state that, "Mineral fibers have been detected in the urine of residents of Duluth

5 DR. MUSTARD: (cont'd.) "in numbers corresponding to the concentration of asbestos in the drinking water".

Then they go on to state:

"Interestingly enough, fibers have been found in the glomeruli and tubules of rats exposed in inhalation chambers to asbestos fibers."

10 Are you at all familiar with that latter piece of evidence?

THE WITNESS: No, no.

DR. MUSTARD: Can you tell us how you think the fibers might get into the...?

15 THE WITNESS: No. I'm sorry to say that's got no further than a note on my desk to look at those particular references that are quoted there.

20 DR. MUSTARD: But I guess it would be fair to say that one has to at least pay attention to that evidence, that there has to be some transport mechanism, there is no way to get fibers there, if in fact they are detecting fibers which have ended there, as these authors indicate that they are?

25 THE WITNESS: Oh, I have no doubt that the fibers are there, and there is a lot of evidence of this. The thing that appears to me to be unlikely is that the lymphatics are a major route of their dissemination. It seems a very difficult hypothesis.

DR. MUSTARD: Could I ask a question? Is there any evidence that the fibers can be transported by cells that have ingested them? Is there any evidence of transportation in the manner of the macrophages...

30 THE WITNESS: I don't think you could distinguish between whether the macrophage had transported them, or been transported with them, or ingested them at the site you happened to find them.

DR. MUSTARD: But as you know, all good pathologists can tell you whether the cell is going or coming.

THE WITNESS: That requires a secret kettle, though.

MR. LASKIN: Q. What do you think is the most likely mechanism by which they are transported, from your own knowledge and experience?

THE WITNESS: A. I think a fair answer would be to say we don't know.

If you get them to the glomeruli, for example, you are almost forced to put them in the blood stream, or else to assume that they just go through the tissue directly.

I prefer the blood stream to the lymph stream, but both that and the direct passage through the tissues seem to me to be improbable mechanisms.

DR. MUSTARD: But in your studies or in other studies...I know you have been looking at mineral fibers in tissues...did you find the fibers in the lymph nodes?

THE WITNESS: You do very occasionally find the fibers in the lymph nodes. We quite often find fibers in the lung where they are lying free in fibrous tissue, which would give some reason to suggest that they perhaps penetrated it directly.

MR. LASKIN: These two studies which you referred to, in which I take it you looked specifically for asbestos fibers in the gastrointestinal tract in the case of what kind of cancer?

THE WITNESS: A. These were gastric cancers.

Q. Gastric cancers. And did you find fibers of what you termed the dangerous length?

A. Yes.

Q. Were they of one particular type rather than another, or did your examination of them go that far?

A. They were certainly amphiboles, and probably

A. (cont'd.) crocidolite.

Q. Any chrysotile?

5 A. I think not. There were very few fibers found. It was a very massive kind of study, since the tissue had to be ashed, digested, examined by a scanning electron microscope - really a very complicated procedure.

10 Q. Can I ask you just one or two other questions about parts of your report, and if you were looking at appendix three and if you carry on to page nine, which is part of paragraph A fifty-four, in which you express your overall conclusions, and paragraph eight addresses itself to whether or not smoking should be taken into account in awarding compensation for lung cancer, and your conclusion is that,

15 "No consideration should be given to whether or not the claimant smokes."

What interested me was the last part of that, paragraph H, where you said that:

20 "While smoking very greatly increases the risk of developing carcinoma of the lung in those exposed to asbestos, that men now or previously employed in asbestos plants could not have known that this was the case."

Are you suggesting that in the future one should look at that question differently if the state of our knowledge is such that we now know of the interaction between smoking and asbestos?

25 A. Well, that of course, paragraph H is a nonmedical opinion and should be so evaluated.

30 The evidence is that in people who smoke and are exposed to asbestos, the risk of carcinoma of the lung is greatly increased. How greatly is, I think, again, difficult to determine since reports differ widely, but greatly is a fair description.

There is little or no evidence, really very little,

5 A. (cont'd.) to suggest that there is an increase in carcinoma in the lung in asbestos workers who do not smoke. The numbers are so small that the data are difficult to assess properly.

If one can extrapolate from other examples, I would expect there was some increase in asbestos workers who do not smoke, but not nearly so great as in smokers.

10 Hence, you could reasonably argue, if you were an opponent to compensating men exposed to asbestos, that the carcinoma is, in essence, due to the smoking and not to the asbestos...which is logical, to my mind.

15 Equally, I think it would be most unfair...now speaking nonmedically...to the workmen involved, since as I say here they had no reason to think that smoking greatly increased the risk they suffered by being exposed to asbestos.

In some happier time in the future, if it were ever possible, it might be desirable to ensure that all people occupationally exposed to asbestos do not smoke. It clearly would reduce the risk they run, very considerably.

20 At the present time it strikes me as unfair to use the smoking as a criterion to refuse or reduce compensation to an asbestos worker.

25 Q. Can I just take you back to page eight of this report for a moment, to paragraph A, of paragraph A fifty-four, conclusion A, which appears to direct itself to the question of compensation for asbestosis?

30 I take it that was one of the issues within your mandate. Do you know...it does not appear, at least, from the subsequent promulgations of the Board, that there was any asbestosis guideline put into place in the same way in which the cancer-related guidelines were put into place, and I'm just wondering whether you know what the reason for that was?

A. No, I do not know that.

5 Q. Can we then...unless the Commissioners have any more questions on the guidelines per se, I was going to turn to Dr. Ritchie's role as a consultant. I won't leave the guidelines if...

DR. MUSTARD: I would like to pose a general problem, and it's in the documentation but I think that one does specifically refer to it.

10 In trying to translate the limited knowledge we have about the pathogenesis of asbestos-associated disease into a clinical program, there is one consideration. Take it from that into administration application and it is even more complicated, in my view, and I would like to hear you articulate a bit about this.

15 What I'm getting at is the enormous uncertainty of, all the way along in the story, and therefore if we turn to the subject of asbestosis, how easy it is, in your opinion, to clinically differentiate the fibrotic reaction of the lung from other kinds of fibrotic reactions that can occur, and at what stage does the disease have to have progressed before you can clinically detect it?

20 THE WITNESS: I think as to the clinical diagnosis of asbestosis, if by that we take clinical to mean diagnosis by radiology, physical signs and so on, I should defer to somebody else, to Dr. Gray. But certainly that is not my field.

25 Pathologically, the diagnosis of asbestosis needs considerable thought. In my opinion, the kind of fibrosis you get in relatively early asbestosis is highly characteristic and while it is not specific for asbestosis, this would cause me to lean very highly to that diagnosis, and the criteria that I would use for this is that it is a patchy fibrosis, quite sharply delimited. It's a very fine collagen. It does not damage the elastic framework of the alveoli, and there are very few things that I have seen

THE WITNESS: (cont'd.) that meet those criteria.

5 Certainly if I saw that, I would not be willing to make a diagnosis of asbestosis unless I could find at least some asbestos bodies, and they are usually very numerous in people with asbestos disease.

But it does seem quite a characteristic kind of fibrosis which differs from others.

10 I have not seen this reported elsewhere. This is merely my own conclusion from the cases I have had occasion to see.

15 If I saw that, I would make a diagnosis of asbestosis with very considerable confidence, but it is a little bit like making a diagnosis of sarcoidosis. You are never a hundred percent sure, you are always going to be something less than that, in that sarcoid could always be an atypical form of tuberculosis. You may be very sure. I could never be quite certain that the man with this kind of fibrosis had not been exposed to something else which caused the fibrosis, and happened to have some asbestos fibers in his lung too.

20 However, if you take this in any sort of reasonable clinical judgement, the diagnosis can be made with very considerable certainty. After all, if you find a man with pneumonia, full of pneumococci in his sputum, it's just possible he has some other organism causing the pneumonia primarily, but it's very unlikely. There is always some doubt in a clinical diagnosis.

25 So if you meet these criteria pathologically, I think the diagnosis is as firm as one can expect in any medical matter.

DR. MUSTARD: You said this was with the early...

THE WITNESS: The early stage.

30 DR. MUSTARD: Is that early pathological stage one which generally is associated with clinical manifestations?

THE WITNESS: Yes.

DR. MUSTARD: So that by early, this is early in

5 DR. MUSTARD: (cont'd.) terms of clinical manifestations. Have you had the chance to look at people who came to you post mortem, without a clinical diagnosis of asbestosis but when you examined the tissues you indeed find what you would consider to be fibrotic changes compatible with asbestosis?

THE WITNESS: Yes. Changes of this sort I found in people who had not had a diagnosis of asbestosis made, on one or two occasions.

10 What I have not seen myself is the late stage of asbestosis that it described in the literature, which is indistinguishable for any other kind of end-stage fibrosis of the lung, apart from the presence of asbestos bodies, and why they might give you a presumption that it was asbestos disease. At that late stage it would be a much more questionable diagnosis, in my
15 mind...pathologically speaking.

DR. MUSTARD: In your experience here, have you had any chance to have access to post-mortem examinations on individuals who worked in asbestos plants and died, but did not die from anything that was identified as being asbestos related, and had a chance to
20 look at their lungs to see what conditions were present? Has that been done by anybody in this area?

THE WITNESS: No.

DR. MUSTARD: It was not done by yourself?

THE WITNESS: If it is not done by me, it has not been done I think is a fair statement, and I certainly have not
25 seen any significant number of such people.

Certainly not enough to draw any conclusion at all. Asbestos workers are rare and the chances they are coming to autopsy and my getting the tissue is also, I suppose, low.

DR. MUSTARD: Then it would be fair to conclude
30 from this that the most distinguishing feature in the early stages, in your view, of the fibrotic reaction to exposure to asbestos

DR. MUSTARD: (cont'd.) fibers is a patchy network...

THE WITNESS: Yes.

DR. MUSTARD: ...with fine collagen?

THE WITNESS: Yes, and preservation of the elastic.

DR. MUSTARD: But that as it progresses, it becomes more and more indistinguishable from other forms of fibrosis...

THE WITNESS: Yes.

DR. MUSTARD: ..of the lungs, and the only identifiable characteristic would be finding asbestos fibers in association with asbestos bodies?

THE WITNESS: Yes. And even that is questionable.

If you are considering the diagnosis from the point of view - can you exclude asbestos disease - the finding of asbestos bodies probably say no.

If you really want to say - is it certainly due to asbestos and not due to some other disease the man had years before - the answer is probably that you cannot say. It is a presumption rather than a final diagnosis.

DR. MUSTARD: One final point on this subject.

Presumably the changes in the tissues have to begin at some time, and probably begin in association with the initial exposure to fibers. How easy is it to draw a relationship between actual first exposure to asbestos fibers and the development of fibrotic changes in the lungs - from the standpoint that you can see as a pathologist, and secondly, from when the clinician may be able to identify those changes, and of course you may defer that to Dr. Gray to later on answer that question, but I would be interested to know if, from a biological point of view, whether you think that the process sits dormant and then suddenly appears, or whether it is a progressive process that eventually becomes clinical in terms of being able to be picked up by the physician?

THE WITNESS: I don't know of any evidence that would enable me to give you any better answer than my own hypothesis. I would favor a gradual development of the condition, but I do not know of any good data in man.

DR. MUSTARD: The animal experimental evidence is just a progressive development?

THE WITNESS: Yes.

DR. MUSTARD: Is that not correct?

THE WITNESS: This is correct.

MR. LASKIN: Dr. Uffen?

DR. UFFEN: I have a slightly different kind of question. It's related to who should do the deciding in certain circumstances.

Earlier on we were talking about the guidelines and the difficulty about putting a fixed number on exposure - ten years or whatever - and there is provision for that, and they are all worded similarly: "Claims which do not meet the guidelines in two, one; two, two should be individually judged on their own merit, having regard to the intensity of exposure and other factors peculiar to the individual case."

Now, my question is one concerning the routing of a case. Who is competent to decide in those cases that are going to be individually judged? Do you have to have medical competence in the area of lung conditions?

THE WITNESS: I think this is very well put in Dr. Little's submission. What you need here is certainly competence in lung conditions, but you need more than that, since I'm sure there are a great many people who are very skilled in pulmonary disease who would see at the best a handful of patients with asbestos disease, in their whole practice.

You really need, as Dr. Little pointed out, to try

5 THE WITNESS: (cont'd.) and attract those people who have considerable experience in this very small piece of pulmonary medicine, and they should make the decision if you can attract such people.

10 DR. MUSTARD: Well, then, in the routing procedure for adjudicating a case, would it be logical for me to conclude that all claims related to asbestos should be routed to the competent medical specialist of the type you just described?

15 THE WITNESS: I think not. I would suggest perhaps there should be established some kind of negative guidelines that would enable a claim to be excluded without taking up the time of the medical board, and these should be really very harsh guidelines for exclusion...a man who has never been exposed to asbestos at all cannot claim for asbestos disease; a man cannot claim for asbestosis if he has, say, a perfectly normal x-ray film.

20 DR. UFFEN: Excuse me for interrupting. That requires some medical ability, training, judgement and experience, and the thing I'm trying to get at is the routing to ensure that the judgement whether to send a claim this way or that way or stop it, is made by the competent person.

You started out to tell me yes, there should be some fairly strict rules so that you don't have everything going to the specialist. Then I see that, the necessity of being able to read and understand the x-ray data.

25 So I'm in difficulty. I'm sorry to interrupt you, but...

THE WITNESS: No, the way I would see it working is very much as it works...that's the way I would see it working in a perfect system. It's very much as it works at present.

30 Somebody like Dr. Stewart would receive the claim. If he were to find that the man had spent his life, shall we say, working as a lawyer in a building that had no asbestos in it, then the claim is certainly ridiculous. There is no exposure.

5 DR. UFFEN: Now, a rather important point. You said 'someone like Dr. Stewart'. In other words, you are assuming that there are competent medical persons available?

THE WITNESS: Yes.

DR. UFFEN: It should not be made...am I correct in saying...it should not be made by someone with no medical training?

10 THE WITNESS: No. because the second point must be that the claimant has something which could conceivably be construed as asbestos disease...and that is a medical opinion.

15 DR. UFFEN: Then I conclude from this that in the adjudication process such claims must be routed to the medical division...whatever it's called or how it's organized...at a very early stage. Then it makes me wonder what's the point of specifying at least ten years occupational exposure or...I'm reading the lung cancer one...or a minimum interval of ten years between the first exposure.. If there are some doubtful cases say two to three years exposure, and only a medical person is capable of making that preliminary judgement, and since they are rare as you have just
20 told us, route the whole works to somebody like Dr. Stewart! It would seem to a layman the right way to go.

Now, am I...

25 THE WITNESS: I think my major purpose here would be to produce something which achieves the effect desired, which I would take it to be that anyone who is exposed occupationally to asbestosis and suffers disease from that cause be compensated appropriately...coupled with the proviso that in case of doubt, the workman gains the benefit of the doubt.

30 If there are in fact so very few cases that are ever rejected that it's not worth wasting Dr. Stewart's time looking through them and they should all go the Board or the medical committee, I would then agree with you.

THE WITNESS: (cont'd.) If there are in fact any sizeable number of cases which are...let me call them frivolous without any particularly evil context, any evil opinion, in that they do not establish any exposure to asbestos or they do not establish that there is any disease present that might be caused by asbestos, then I think those should be excluded to save the cost and time of the advisory committee.

DR. UFFEN: Can I pursue it one step further, because we have a situation that keeps recurring in all our hearings, and that is the situation where a workman is not normally engaged in an asbestos-manufacturing process, but in some other capacity he is maybe subjected to rather intense exposures for short periods of time - the demolition industry is one where this might happen - and so that the question, the degree of exposure and the length of time and whether it is going to have a medical consequence which is compensatable, becomes very dicey, but nevertheless a real possibility that is worrying people.

So with that as a specific example, could you advise...how would you think such a case should be routed?

THE WITNESS: I would think such a case should be sent to the advisory committee.

DR. UFFEN: The medical advisory...

THE WITNESS: The medical advisory committee.

DR. UFFEN: With no opportunity for it to be stopped elsewhere in the adjudication system, until at least...

THE WITNESS: Yes. Supposing that there is a history of asbestos exposure of the kind you outline, which I perhaps should say in parentheses should be studied by the appropriate nonmedical people to assess as best they can what that exposure was and so on and so on, gain as much information as is practicable... the second question is then whether this man has disease, and that is the medical committee's responsibility.

5 THE WITNESS: (cont'd.) They then have to decide, if he does have disease, whether this is likely to be asbestos-related disease or whether there is some other cause.

For this they need to have all the usual data on which you can make such an opinion.

10 DR. UFFEN: Now, I still want to narrow in on the one thing that is still a stumbling block for me, and that is the question of whether the short-duration-but-intense exposure would be large enough to merit consideration.

15 I think you just said a minute ago there might be some other group of people in the medical who would assemble the information. What worries me is about whether someone with no medical training, incapable of really deciding whether there is a likelihood of disease, will say, 'oh, two hours, so many fibers per centimeter or per cubic centimeter, that's not enough', and will make a decision that appears to me at the moment requires a medical contribution.

20 How do we decide, I guess, what is too little to merit a medical evaluation?

25 THE WITNESS: I think my answer to that, in this very early stage of the process when the man's claim is really just entering and about to be considered, is, 'too little exposure to asbestos is none'. As I said, a lawyer who has never had any exposure to it at all clearly would not sensibly advance a claim that he has got carcinoma of the lung because he is exposed to asbestos. The man in the demolition industry has got a prima facie case that it might be.

30 I think at this level of judgement the judgement was best done by a medical person, since it's really all or nothing, and he can also answer the second question - is there disease which might be consistent with asbestos-induced disease, and here I certainly mean 'might'. He need not be convinced in

THE WITNESS: (cont'd.) the slightest, but if there is a chance, then it should go forward.

DR. DUPRE: Dr. Ritchie, before we leave your guidelines, I just want to review a couple of points that came up in your answer to counsel.

To help my review along, I have found your July 27th report very useful. That is in appendix four, I guess, before you. Can you find that somewhere?

THE WITNESS: I have it.

DR. DUPRE: Okay. I'm looking at page four, Dr. Ritchie, and starting with B twenty-nine, I note the point:

"It is usually assumed that if exposure to asbestos does increase the risk of developing gastrointestinal carcinoma, the increased risk results from swallowing asbestos fibers which penetrate the gastrointestinal mucosa and so induce the carcinoma. There is no evidence that this is the case."

Then B thirty and B thirty-one, and B thirty-two, are all propositions that dwell on the absence of cancer, of detectible cancer, among individuals who have been drinking asbestos-contaminated water.

So at this juncture we go to B thirty-three, where the proposition is:

"Thus, if there is an increase in gastrointestinal carcinoma in asbestos workers, this must be because they swallow much greater quantities of asbestos than are taken by drinking contaminated water, or because the asbestos to which the workers are exposed is in some way different."

Now, can I take it that in your answers to Mr. Laskin you have supplemented B thirty-three with...can I maybe

5 DR. DUPRE: (cont'd.) summarize it and maybe two additional hypotheses? One would be that if there is an increase in gastrointestinal carcinoma in asbestos workers, this might be because fibers inhaled into the lungs, having been cleared, were swallowed and passed into the gastrointestinal tract in large amounts. So that will be a competing hypothesis, or a complementary hypothesis for that matter, to eating a great deal more asbestos if you are a worker. Fair enough?

10 THE WITNESS: Yes.

DR. DUPRE: And can I take it that the other supplementary hypothesis which you have advanced is that asbestos fibers may stimulate the production of carcinogens in a part of the body in which they are not themselves present?

15 THE WITNESS: Yes.

DR. DUPRE: And that, therefore, would update the hypotheses that I could add to B thirty-three in my student's notebook?

20 THE WITNESS: Yes. I can indeed perhaps add a few more that are even less probable, in my opinion.

I should say that the statement in B twenty-nine, 'there is no evidence that this is the case', is now not true. We now do have evidence that this is the case - that is, that asbestos fibers can penetrate the gastrointestinal tract.

25 MR. LASKIN: Q. That's your own...

THE WITNESS: A. This is both.

Q. ...amongst others, your own two case studies that you refer to?

A. Both the case studies we did ourselves here, and other reports in the literature. Asbestos fibers have been found in the wall of the bowel.

30 MR. LASKIN: Dr. Mustard?

5 DR. MUSTARD: Did I not raise the hypothesis that they still could have gotten there by some other route than penetration of the gastrointestinal tract?

THE WITNESS: This is right. All we know is that they are there, in the sense of know...

DR. DUPRE: It could have got there, as well, by some other route than being swallowed?

10 THE WITNESS: We don't know how they got there. The usual presumption has been, indeed, that they were swallowed just there near the surface, but you can find them far from the surface, too.

15 MR. LASKIN: Q. But is that a qualification on the chairman's second hypothesis that he put to you? That is, that while it may be that gastrointestinal cancer is stimulated by something happening in another part of the body, nonetheless there still is some evidence that in some cases asbestos fibers are going to be there?

20 THE WITNESS: A. The fibers are there, at least in some cases. That is still not to say that the fibers, by being there, did induce the carcinoma. The other hypotheses are still possible.

25 All we indeed know is that carcinoma of the stomach is more likely in people exposed to asbestos industrially, and from that we have only got a series of fancies as to how the asbestos causes the carcinoma. We haven't got a proof.

DR. DUPRE: Just to make sure I understood one point that you advanced with respect to B twenty-nine, Dr. Ritchie, what I understood you to say was that you now have evidence that fibers have been found in the tract?

THE WITNESS: Yes.

30 DR. DUPRE: But as I read B twenty-nine, that does not in any way contradict the hypothesis there, because what it says

5 DR. DUPRE: (cont'd.) in the point about there is no evidence simply relates to the proposition that it is usually assumed...da, da, da, da, da...that the increased risk results from swallowing asbestos fibers, which penetrate.

10 Now, we do now know that they have penetrated the tract, but the point of B twenty-nine that remains intact, as I would take it, is that you still don't have any evidence that tells us for sure that they got there by swallowing, as opposed to another process.

15 THE WITNESS: There is experimental evidence in which animals have been fed asbestos fibers, and they have been found in the wall of the bowel. The asbestos fibers, I think, if my memory serves me correctly, had been given by lavage into the stomach.

DR. DUPRE: Right. But did those animals develop cancer?

THE WITNESS: Not so far as I know.

DR. DUPRE: That was my impression from...

20 THE WITNESS: I'm afraid B twenty-nine is in fact even worse. It's ambiguous, since it's not clear what I mean by saying that there is no evidence that this is the case, for those various statement preceding. It should have been clarified.

25 DR. DUPRE: Now, you volunteered to offer a couple of additional hypotheses to the ones that I had summarized in my notebook here as being, one: fibers inhaled into the lungs can be cleared, swallowed and through that route pass into the tract; the other hypothesis being that asbestos fibers may stimulate the production of carcinogens in parts of the body where they are not found.

30 I am all ears to add to my lecture notes, Dr. Ritchie, if you wanted to toss out a few more.

THE WITNESS: You can add the observation that certain carcinogens are selectively adsorbed onto asbestos fibers.

5 THE WITNESS: (Cont'd.) A suggestion has been made that they might be carried into the cells by the fiber, and the fiber just serves as a transport mechanism.

Again, carcinogens are adsorbed. There is no evidence that this is of any significance.

10 Chrysotile at least is capable of damaging cell membranes, and there are a number of tests which have been devised to show that this is the case.

It is reasonable...a reasonably hypothesis would be this membrane damage, in some fashion, is carcinogenic. There is no evidence that that is the case.

Those were the two that were in my mind when I said there were a couple of others.

15 MR. LASKIN: Q. Could I just ask you a bit about the two case studies that you referred to? Is this part of a larger case study, or were just two cases of GI cancer selected out for tissue evaluation?

20 THE WITNESS: A. This was done at the time that the question of compensating people for gastrointestinal tumors had first come up, and one of the problems before us at the time was that there was then no good evidence that asbestos was present in the bowel, or in relation to these tumors at all.

Hence, we looked in these two patients which came up at that time, to see if we could find asbestos fibers.

25 Q. I take it these two patients were known asbestos workers?

A. Yes.

Q. From Ontario?

30 A. I believe they were both from Ontario, although one of them died in British Columbia. I think his exposure must have been here.

MR. LASKIN: Would this be a convenient time to take a short recess?

DR. DUPRE: Shall we recess for about fifteen minutes?

MR. LASKIN: Sure.

THE INQUIRY RECESSED

- - - - -

THE INQUIRY RESUMED

DR. DUPRE: Shall we resume?

MR. LASKIN: Yes.

Dr. Mustard?

DR. MUSTARD: Dr. Ritchie, in your first report, which I think is appendix two of the document, on page fourteen there is an item eighty-four, which talks about studies to evaluate the intensity of contamination of the lung with asbestos, which I would gather you initiated at the Toronto General Hospital.

Has that study been finished? Has it been reported?

THE WITNESS: No, it hasn't. What we did and have done is to establish a standard technique for digesting samples of lung and counting the asbestos bodies present in the samples, and took as a normal population people coming to autopsy without any suggestion of asbestos disease, and then of course comparing them with people exposed to asbestos.

The difference between these two groups is usually very great, in that most people - a great majority of the normal population - have something under ten asbestos bodies per five-gram sample that we use. People with significant asbestos exposure have several thousand, so it's an enormous difference.

Clearly, you do get occasional people who sit in the uncomfortable intermediate ground.

Now we have never, in fact, published those, or indeed formally statistically analyzed them, and at the moment

THE WITNESS: (cont'd.) are doing so.

5 DR. MUSTARD: You were not looking for asbestos fibers, then? You were looking for asbestos bodies?

THE WITNESS: Yes. Asbestos fibers are technically very difficult to identify.

10 DR. MUSTARD: But now there are, I think what, two studies in which ...one in Wales in which they have looked at fibers in the lung, and one in France where they have looked at fibers in the lung...and as I recall that data, which has been... part of which has been presented to the Commission...it was that there wasn't as much difference when they were looking at actual fibers they could find in the lung, between the so-called control population and the workers exposed to asbestos.

15 Do you have any comments on those studies, in the light of your own studies?

THE WITNESS: Yes.

20 Firstly, we will do a similar study in that the tissue has been sent to McMaster and it is being studied in the unit there, and at some point one of the pieces of that study will in fact be to use electron microscopy and so on, to identify the total fiber content, We can then correlate that with the asbestos-body count as we do it, which would be particularly useful since the asbestos-body count is a practical thing to do in a large number of patients and can be readily applied.

25 The search by electron microscopy for fibers is just impractical on a widespread scale.

30 The problem, too, if you look at all the fibers, is that the great weight of the data does suggest very strongly that it's only the fibers longer than five mu and appropriate diameter that are dangerous. The value, therefore, of counting vast numbers of fibers that don't meet this parameter seems to be highly questionable.

5 THE WITNESS: (cont'd.) It is, however, I think, still a moot point, and we need more data to relate the findings by electron microscopy with different lengths of fiber appropriately classified, and the clinical result.

DR. MUSTARD: Do you recall whether the studies in Wales or in France also looked at asbestos bodies, in those studies?

10 THE WITNESS: My memory is not.

DR. MUSTARD: So that would be the difference.

15 Now, in some of the data that we have been given about fibers, some people are going to find that when people are exposed to dust they have a range of fiber size in the particle count, and that although when you are looking at fibers in the lungs you may be counting everything, that there would also be a cohort of the bad fiber size present.

I get from your comment that you think that it might not...that there may be exposures in which people have fibers which are really largely innocuous and do not have any of the dangerous fibers, that that possibility occurs?

20 THE WITNESS: I've thought that the possibility probably...or theoretically that it should occur, and the one particular group which I have often wondered might not be an example of this reduction of the fibers to too-short a length to be dangerous are the people who work with brake linings, since with a very few examples they do not seem to get asbestos disease, and the few examples I've heard of had quite extraordinary kinds of exposure. One man was described to me as grinding brake linings, in which to avoid the dust exposure to the rest of the people, they had a little tent that he went inside and remained there during the proceeding, and did develop what I'm told was asbestosis -
25
30 this being an anecdote which was told to me by somebody else.

But I can imagine that the grinding process might

5 THE WITNESS: (cont'd.) in fact reduce the number of dangerous fibers. I don't know of any data as to whether this is or is not true.

MR. LASKIN: Q. I was going to go to a slightly different...but on the same track. I was really going to ask Dr. Ritchie whether...well, I'll step back.

10 Do I understand that in terms of claims for mesothelioma before the Board that generally speaking all of those claims find their way to you at some stage?

THE WITNESS: A. I imagine all those in which tissue is available, a high proportion at least. Dr. Stewart would be able to tell you that better than I do.

15 Q. In all of those in which there is some tissue available for analysis, you get it?

A. Well, again, Dr. Stewart will have to tell you what proportion I get. My assumption is it's a high proportion.

Q. Do you then, I take it, look at the tissue for asbestos fibers, as opposed to asbestos bodies?

A. When possible.

20 Let me see, I certainly look at it in the ordinary histological fashion anyway, with the purpose of saying is it a mesothelioma or isn't it, with the usual problems that are involved in doing that.

We would certainly look for asbestos bodies histologically.

25 If there is enough tissue, we would digest it and look for asbestos bodies and quantitate them in that method.

30 We usually have done, on these patients, a considerable battery of special stains which have been purported at one time or another to be of value in distinguishing between carcinoma and mesothelioma...I must say, without gaining any confidence in their use for this purpose...and commonly we look at the tumors

5 A. (cont'd.) by electron microscopy, which is probably the best way to confirm a diagnosis of mesothelioma, available to us, even though the tissue we have to use for this purpose has not been prepared for electron microscopy and therefore the quality of our electron micrographs is atrocious.

They usually do preserve enough to enable us to confirm a diagnosis of mesothelioma with some security.

10 Q. Are you looking at, when you look at the tissues by electron microscopy, are you able or do you seek to determine what fiber type you find?

15 A. No. No. Indeed, this would require a different kind of examination altogether. With the destruction of the tissue, we use the electron microscope diagnostically to confirm the diagnosis of mesothelioma.

Q. Have you done any studies on any of these cases which would seek to distinguish amongst fiber types, in terms of what fibers are found there?

20 A. No. But as I mentioned in reply to Dr. Mustard a moment ago, the tissue from the cases sent to me goes to McMaster, and one of the studies which will be carried out on this tissue will be an investigation of the kinds of fibers that are in these lungs.

25 DR. MUSTARD: I would like to turn to another problem in this area, and get your views on it. It's the question of host susceptibility to exposure and the recognition that certain of us are more susceptible to the development of cancer, I think you would agree, is a fairly well-established point indeed.

THE WITNESS: That's clear.

30 DR. MUSTARD: There are people who believe that there are some individuals with certain kinds of characteristics who are very susceptible.

Do you know if there is any evidence in relation

DR. MUSTARD: (cont'd.) to asbestos exposure and cancer, as to whether host susceptibility has been or can be identified?

THE WITNESS: I know of none.

DR. MUSTARD: No one has tried to look at that?

THE WITNESS: It is clearly a major factor.

DR. MUSTARD: I was wondering a bit also about the question of chronic chest disease, fibrosis, and whatever your views are as to why some of us get chronic chest disease - smoking or other things. Not everybody who seems to do these sort of things develops it.

Is there any evidence about host susceptibility to developing chronic fibrosis of the lung, that you are familiar with?

THE WITNESS: Again, that there is individual susceptibility is clear, I think. Some people do, and some people do not suffer fibrosis, given what seems to be an identical insult.

Again, I know of nothing to suggest what the factors that control that susceptibility might be.

DR. MUSTARD: This takes me to a problem that we have had all the way through in our hearings, and we certainly have it as we take on the compensation issue. This is the relationship between exposure, time and the development of manifestations of disease, and in your appendix three there are some guidelines that you propose as guidelines for latency considerations in terms of what seems a reasonable duration between exposure and development of symptoms. But in another part of your documentation you carefully point out the uncertainties in this subject, and I would like, if I may, to read to you an article, a comment of Margaret Becklake, of the June 17th issue of the editorial of the New England Journal of Medicine in which she states, and she had been talking about the host susceptibility question in part:

"Thus, in considering the individual patient with

5 DR. MUSTARD: (cont'd.) "a disease known to be related to asbestos exposure, the wise clinician should avoid regarding any particular exposure as too short, too remote or at too low a level to have accounted for the disease." End of quote.

10 I wonder if, in the light of where we are know in our understanding of biological processes and the uncertainties in here, how you really feel about trying to take latency periods and impose them in trying to cope with the problem of exposure and the development of disease, because I would think...and you could say this is wrong...that one could argue that there are many individuals whose susceptibility is such that a relatively short latency period indeed might be involved in the development of clinical manifestations.

15 So if you would just comment on that whole subject and what you think, at this period in time it might be a sensible approach to this field because I realize that appendix three was written in 1976, and it's now 1982.

20 THE WITNESS: Yes. I think when you take...and if we just take latency as an example...if you take anything and you provide a numerical criterion - let's say that there must be twenty years since the first exposure to asbestos and the development of a mesothelioma - this statement is only sensible if you take it to mean that in the majority of patients there is that degree of latency.

25 Now, as I said earlier, I don't think any guideline of this sort should be used for any purpose except to award compensation, in the compensation context. If there is that degree of latency - good. If there is good exposure - good. In the case of a mesothelioma the reasonable assumption is that the asbestos caused the mesothelioma, and everything follows.

5 THE WITNESS: (cont'd.) If you find somebody develops a mesothelioma ten years after the beginning of exposure, then I think you must consider that case quite individually, and there are a number of measures which would occur to me. One is to see if indeed the exposure did begin ten years ago, or whether there was not some unsuspected exposure before, and this is always possible.

10 I remember one patient in which we did analyze the lung for asbestos fibers, to determine the type of fiber present, because the patient had a history of exposure to glass wool, which conceivably could have had similar-sized fibers.

15 He was an intelligent man who understood the circumstances. Questioned by numerous physicians in the Toronto General Hospital, he denied all exposure to asbestos. And yet when we analyzed the lung he had crocidolite fibers in his lung. Hence, the history must always, I think, be questionable.

20 In the case of a mesothelioma, the presumption of asbestos is very high. So I think the guideline should be used to establish clear compensatability. If you don't meet the guideline, then I think medical judgement must assist in the ordinary way.

25 DR. MUSTARD: But you, I think, indicated, if I interpreted your comment correctly, that the latency is an average, it's an estimate, and it's based on the uncertainty in all the literature about the actual exposure.

THE WITNESS: It's below the average. It's the...the vast majority of cases had at least twenty years.

DR. MUSTARD: All right. It's susceptible to the fact it does not take into account individual host susceptibility.

30 THE WITNESS: That's right.

DR. MUSTARD: And you are saying the way that should be handled is by an individual judgement by a group of experts?

THE WITNESS: By a group of experts.

5 Again, I think in this particular context with the bias towards the workman's compensability. In case of doubt, he should win.

DR. MUSTARD: Let me take you to the one that really gives me the most difficulty. That's the ten year guideline on asbestosis, as I interpret it. I think it's fifty-four, F, B in appendix three.

10 Maybe I'm interpreting it incorrectly.

MR. LASKIN: Page eight?

DR. MUSTARD: That's right. Page eight.

Have I got the right one?

MR. LASKIN: Of appendix three?

15 DR. MUSTARD: Yes.

It says:

"All exposure to asbestos of reasonable severity would develop pulmonary fibrosis of the type recognized as caused by asbestos, ten or more years after the beginning of exposure."

20 How hard should that guideline be...if one assumes any host variability in response to exposure to a stimulus to cause fibrosis, variation in terms of knowing the extent, true extent of exposure, and the biological conclusion which I think you agreed to earlier on that the process is probably a progressive process - that is, a biological reaction starts in the lung when the fibers come in, and it takes time for the clinical manifestations to occur and put into that the thing which I know we reserve to our physician colleagues to sort out for us, but the fact that as individuals illness is when we decide that the problem bothers us, even though the disease may be present, and I think we are well aware of people having disease who never say they are ill,

25

30

DR. MUSTARD: (cont'd.) and conversely, people who feel ill who have rather minimal disease.

Now, my problem is, the biological process of it going on, and the latency period put in and dose and other variables, and problems of the individual's recognition of feeling ill, and trying to set up a guideline with a ten year principle, and how you are going to interpret somebody who comes down with fibrosis of the lung seven years after a fairly steady, constant exposure to asbestos.

THE WITNESS: Again, I think the same answer I gave you before. If there is exposure for more than ten years and the patient has fibrosis compatible with the diagnosis of asbestosis, does not have other obvious cause for that fibrosis, he should be compensated.

If his exposure is less than ten years, then it should be considered on an individual basis, and clearly one would consider principally then the nature of the exposure, because there is no way in which we can determine whether or not he was unusually susceptible.

DR. MUSTARD: What about genetic history?

In cancer there certainly are genetic histories of cancer that you can sometimes bring in. Is that ever used in any consideration in terms of host susceptibility?

THE WITNESS: I don't think it would be practical in this context, since how many asbestos workers would in fact have any relatives exposed to asbestos.

DR. MUSTARD: I'm thinking of cancer susceptibility in general. Do you know if any cases have come up in which in the family tree there just is a pattern of people coming down with cancer and dying, and indeed this is a person exposed to asbestos who developed at a much earlier stage than perhaps the norm?

5 THE WITNESS: No. Of course there are many reports of this sort of thing, principally in carcinoma of the breast, but I know of none in relation to asbestos.

DR. MUSTARD: So there is really no way that the host susceptibility question, you feel, can be easily handled in terms of assessing of the earlier manifestations?

10 THE WITNESS: No. All that one can do is recognize that it exists.

DR. MUSTARD: I want to ask one more set of questions in another area.

MR. LASKIN: By all means, go ahead.

15 DR. MUSTARD: Having a long experience as a pathologist, I would appreciate hearing your views of the relationship between chronic fibrosis of the pulmonary bed and its affect on the circulatory system overall. I'm not as concerned about right heart failure as I am concerned about your views about whether it has any additional effects in the circulatory system, or views about the impairment of pulmonary function, say, on the function of the coronary arteries, particular
20 in the relationship to people who have got fairly advanced coronary artery disease.

THE WITNESS: Again, I'm not sure you should not address this question to Dr. Gray rather than to me.

25 The number of the studies on the pulmonary circulation in a pathological sense have been exceedingly few, and we really do not have good data derived in that fashion. I would much sooner rest on data from angiograms and such things done during life, and would refer that one to Dr. Gray.

30 I am highly skeptical that minor degrees of pulmonary fibrosis have any effect on the coronary circulation. There is no doubt that if you imagine a patient who has got massive pulmonary fibrosis, massive pulmonary hypertension, cor pulmonale,

THE WITNESS: (cont'd.) right-sided heart failure, clearly the coronary circulation is going to be troubled by this series of circumstances.

But that's an extreme. The average person with minor degrees of fibrosis I don't think has any increased risk of coronary failure.

There are, in the literature, papers studying not asbestosis, but silicosis, in which they have failed to show an increase of myocardial infarction in patients with moderate to mild degrees of silicosis, which indeed I think is reasonable.

DR. MUSTARD: I guess the problem, if you look at other forms of pulmonary fibrosis, you've got a smoking problem.

THE WITNESS: Well, in all of them, yes.

DR. MUSTARD: That's entirely cross-linkage.

Let me ask you another question about this, and I'm afraid I can't go to the exact reference, but in reading through the material...maybe it's in appendix three, or maybe it's in the other one...you talked about the appearance in the blood of rheumatoid-like reactions.

Has there been any further development in understanding why these characteristics appear in the blood of people who have got asbestos exposure and chronic chest disease?

THE WITNESS: Not so far as I know. This, I think, was Turner-Warrick, wasn't it? So far as I know, it's just an isolated observation.

MR. LASKIN: Dr. Uffen?

DR. UFFEN: I want to ask a question which may turn out to be extremely naive, but in the guidelines for adjudication they use the expression, "there is a diagnosis of frank asbestosis".

Does the word 'frank' have a peculiar meaning in medical usage, or is it just the usual English...?

THE WITNESS: I perhaps shouldn't convict medical

5 THE WITNESS: (cont'd.) usage. What I really meant by that was that if you imagine Dr. Mustard saying that asbestos is a gradually developing condition, frank to mean that it is developed to such a degree that the diagnosis was as certain as that diagnosis is ever...can ever be made. Whereas, there is a kind of grey zone when you really wonder whether the man has got a little fibrosis, or perhaps he has...

10 DR. UFFEN: So I can...unequivocal is the...

THE WITNESS: Unequivocal would be simpler.

15 DR. UFFEN: And just so I don't get lost again, that interesting discussion you had a few minutes ago about the asbestosis and the time interval, ten years and so on, there is no mention of time in the guidelines that are currently in use, am I right?

THE WITNESS: I'm not familiar with the guidelines in use.

20 DR. UFFEN: I see. All right. The ones we got yesterday had times involved for lung cancer and mesothelioma, but it's notably missing from the asbestosis guidelines.

So your discussion then, just now, was not about the currently-used guidelines?

THE WITNESS: No. I was speaking about the statement in my own report.

25 DR. UFFEN: Your own recommendations? Okay, thanks.

DR. DUPRE: Dr. Ritchie, were you involved in the guidelines for asbestos fiber dust effects?

THE WITNESS: No. I must say I did not know about the asbestos fiber dust effect until I read the report by Barth.

DR. DUPRE: Thank you.

MR. LASKIN: Q. Just before I leave this...

30 DR. DUPRE: Incidentally, since I have just raised that, when you discovered this in Barth, I just notice...I note, of

DR. DUPRE: (cont'd.) course, that he provides a description of the criteria. Did they make sense to you?

5 THE WITNESS: I cannot say that I considered them with any great care. I would take it that this process could be two things - the very earliest stages of asbestos injury to the lung - it could be a very minor degree of what will subsequently be asbestosis, not sufficiently developed to enable a diagnosis to be made.

10 The other possibility that I would wonder about is whether there was possibly some change in the small airways, which was evident early in the process. I don't know that there is any such change, but it would be possible.

15 MR. LASKIN: Q. The criteria...and I appreciate you haven't had an opportunity to look at them in detail...are nonetheless quite specific in terms of the kinds of radiological signs that you need and the additional evidence that one needs, and I'm just wondering from your experience could one be this specific about setting out criteria for a diagnosis of asbestosis?

20 THE WITNESS: A. Well, I don't think those are criteria for diagnosis of asbestosis. Otherwise, of course, that diagnosis would be made.

They are criteria for suggesting, probably, that there is something slightly, very slightly, abnormal with that man's lungs - probably so slightly abnormal that he suffers no disability of dysfunction.

25 Q. No, I agree with that, but if you take it to the next stage and you look at the true abnormality asbestosis, could you...I mean, would it make sense to devise a set of criteria that were as specific as the set of criteria that we see here for the asbestos fiber dust effects?

30 A. I think this becomes a very difficult question indeed. I cannot tell you what the clinical manifestations would

A. (cont'd.) be of very minor asbestos disease.

5 This would...very minor asbestosis, using asbestosis in a pathological sense..what the patient would show, if anything, the answer may well be no abnormality whatsoever when he just has the very minimal degree of fibrosis of the lung which is called asbestosis.

10 I can see that desirability, if it were possible, of establishing the minimal signs of asbestos injury to the lung, and if you could do this, of moving anyone that showed such injury from exposure to asbestos.

15 Now, in practice this, I think, becomes a very difficult question since we don't really know that those criteria reflect the minimal asbestos injury, and is it reasonable to require somebody to undertake a major disturbance of his occupation, perhaps greatly to his detriment, on such flimsy evidence?

In the best of all worlds, certainly you would move him to somewhere else. In the real world, is it reasonable to propose to do so?

20 Q. Just before I leave this New England Journal of Medicine article which Dr. Mustard referred to, I note the authors addressed the question of the mechanism, or possible mechanisms, of asbestos-induced carcinogenesis in the respiratory tract, in the lung, and put forward several possible alternative explanations, and I take it were candid to admit that the subject
25 matter is quite unclear.

Can I ask you, from your own knowledge and your own experience, whether you have any explanation as to what might be the more likely mechanism? A more likely mechanism?

30 A. No, I find all the proposals somewhat improbable, and I think the truthful answer is we do not know. We have a number of little pieces of information which do not add up to an

A. (cont'd.) explanation. Which of them are relevant, which of them irrelevant, we do not know at the present time.

Q. So that if I'm reading this article on these possibilities, I should read it with some skepticism?

A. You should read it...I was going to say like a fairytale, but with a slightly greater reality than that - with some skepticism.

Q. Just...

A. The purpose, I should say, of course, of raising these theories is to disprove them, or perhaps in one case, prove them.

Q. Just one final question, and it's this - it really relates to all of the animal experiments...I take it a number of which you have considered in your literature reviews.

Have you got any judgement as to the kind of reliance one should place upon the animal evidence in this field?

A. Let me say essentially what I say to medical students, or have said for many years, that if you take benzpyrene - which is a very famous carcinogen - and paint it on the skin of mice and rabbits and rats and guinea pigs, you will get lots of tumors in the rabbits - an incredible number, a moderately-large number in the mice, a few in the rats and none in the guinea pigs.

Whereas if you take the same carcinogen and inject it below the skin, you will get an enormous number of tumors in the rats, none in the rabbits, none in the guinea pigs, and a moderate number in the mice.

So if you were to extrapolate that data to man, you would have to decide whether you thought men were mice, rats, rabbits or guinea pigs.

The truthful thing, I think one should do, is take

5 A. (cont'd.) the animal evidence as highly suggestive, particularly in its mechanistic aspects of things that happen to carcinogens. But before you can with confidence apply them to man, you have to show that the same process does occur in man.

Perhaps as a further example of the problem, arsenic is a well-known carcinogen to man, but not to animals.

10 Q. Can we then turn, just for a few moments, more specifically to your ongoing role as consultant to the WCB, and can I first of all ask you how long you have been a consultant to the WCB?

15 A. I'm sorry I didn't look the figure up, but it must be in the very early sixties that I started looking at the material.

Q. Has your contact always been through the medical services division?

A. Yes.

Q. What kind of...

20 A. Perhaps I should modify it just a little bit. The material sent to me by the Board comes through the medical services division, from Dr. Stewart or Dr. Dyer usually.

25 There is material which is relevant to this issue, perhaps, that I do get from other sources, though in lesser supply. Pathologists not uncommonly send me the lungs of patients they think have occupational diseases, in which case the report that I give, of course, goes to the pathologist who sent the lungs to me, and it may or may not get to the Board.

30 Occasionally I get requests from the relatives of somebody who has died, or occasionally from the man himself - he has had a biopsy - to review some material that was taken, in which case, of course, the report then goes to him or his relatives, and they may or may not send it to the Board.

A. (cont'd.) So largely from the Board, but there are some relevant cases that come by other routes.

5 Q. And indeed I take it from what you have just said there may be a case or two in which your report will go in, in fact, in support of, directly in support of a claimant's application for compensation?

A. It could, I suppose, be so used. Yes.

10 Q. What kinds of issues, typically, are you being asked to deal with when a case comes from the Board?

A. In the particular case of asbestos, the major question is the diagnosis - does the patient have asbestosis, does he have a mesothelioma, does he have carcinoma of the lung, whatever.

15 The second point - is there evidence in the tissue of exposure to asbestos, which as I said earlier, is best assessed with means available to me by digesting and counting the fibers, the asbestos bodies...less efficiently assessed by looking at the sections to see if I can see them in the tissues.

20 Q. What kind of information do you get from the Board when you are asked to deal with one of these cases? What, typically, do you get?

25 A. I get usually a very short history, which may say something that the man was employed in Johns-Manville for twenty years, or we have no history of asbestos exposure, or the asbestos exposure seems to be slight - some rather general statement of that sort.

Q. Prepared by whom?

A. Prepared by the medical branch - by Dr. Stewart or Dr. Dyer most often.

30 Together with such information as the Board has about the clinical findings leading up to the patient's death, if it's an autopsy, or to the biopsy if it's a biopsy.

A. (cont'd.) This information is not usually in any detail.

5 Q. Do you get medical opinions, medical reports, which may have been prepared by the claimant's own doctor?

A. Often, yes. Or sometimes, yes, I should say, where such reports have been filed...sometimes I get a considerable file of information where in fact the Board has a considerable file of relevant information available to them.

10 Q. Do you ever conduct an examination of any of these potential claimants, yourself?

A. No.

15 Q. In the case of asbestosis claims, do you know whether the case comes to you before or after it goes to the advisory committee?

A. No. I assume it comes before, if the report goes to the advisory committee, to the patient with asbestosis.

Q. Is there any dialogue between you and the advisory committee in any of these particular cases?

A. No.

20 DR. UFFEN: Could I ask just a little question here? When you are doing some of the pathological work, do you do it yourself or do you have a competent technician over whom you accept the responsibility?

25 THE WITNESS: There are different kinds of material that come - I suppose three different kinds. If tissue is sent - say at an autopsy or from a biopsy - and I look at the tissue myself, take some samples of it as I think desirable for microscopy, and these are then prepared by the usual technical methods - stained and what have you - and I then look at them microscopically and write whatever...

30 DR. UFFEN: In the special case of asbestos, the identification of asbestos, would you have to accept a report from

DR. UFFEN: (cont'd.) some laboratory that has used more than the microscope to identify...the optical microscope?

5 THE WITNESS: If we do...if the studies...if we count fibers by the digestion technique, this is carried out by the chief technologist in the Toronto General Hospital.

When we first established the technique, we did them together for a considerable time, and now he does the counting.

10 DR. UFFEN: Do you have the facilities there to make the transmission electron microscope identification so that you can distinguish between crocidolite and chrysotile?

THE WITNESS: No, we do not.

15 DR. UFFEN: But you are able to tell the difference between an asbestos fiber and some other kind of fiber?

20 THE WITNESS: No, indeed not. The things that I look for are asbestos bodies rather than asbestos fibers - that is the fiber which has been coated by a protein coating impregnated with, particularly iron, which we usually stain to make the body evident, and there is some minor possibility that these might not be asbestos.

But the risk, I think, is so low that the presumption is that they are asbestos fibers which have been coated.

25 The only case that we specifically searched to see if the fibers were asbestos was the one I mentioned earlier, in which the man had a history of exposure to glass fibers, but not asbestos.

DR. UFFEN: In the handling of the tissue, what you have to do, what kind of temperature do you have to go to? You dispose of the carbon, I suppose. Do you burn it? Heat it up?

THE WITNESS: Not in any of the things I do.

30 The histology, of course, the last thing I want to do is damage the tissue. It is usually damaged enough by

THE WITNESS: (cont'd.) the time it gets to me, to give enough problems.

5 And for the counting of the bodies, we digest it using, in fact, Javex, which is very good solvent for tissues.

DR. DUPRE: Can I ask you, Dr. Ritchie, do you from time to time get tissue from individuals who have had silicosis?

THE WITNESS: Yes.

10 DR. DUPRE: And you can tell by examining tissue whether the individual indeed had silicosis, as distinct from asbestosis?

THE WITNESS: Yes. The changes are very different.

I could give you some pictures to show you what the two things look like, because they are really very different.
15 Very commonly people have both asbestosis and silicosis - that is, people who have asbestosis often have silicosis, too.

People who have silicosis, of course, rarely have asbestosis. But they are very different reactions.

20 DR. DUPRE: I just take your word absolutely, that they are easily distinguishable.

Are they similarly easily distinguishable in terms of a clinical diagnosis?

THE WITNESS: Again, I should prefer that one to Dr. Gray, but the answer I think would be 'usually'.

25 DR. UFFEN: Have you ever seen an example of damaged lung from fly ash?

THE WITNESS: No.

DR. DUPRE: Just one other very layman's question, Dr. Ritchie. Is it relatively easy for a pathologist to distinguish whatever various forms of pneumoconioses an individual can acquire?

30 THE WITNESS: Let me qualify that before I answer by...you should say 'which pathologist', because I regret to say that most pathologists see so little of the occupational lung

5 THE WITNESS: (cont'd.) diseases that they are commonly getting the diagnoses wrong. In particular, silicosis tends to be mistaken for tuberculosis. The lesions are a little bit alike.

Asbestosis is likely to be missed altogether unless there is good reason for thinking of the diagnosis.

10 Hence, it's the policy of the Board, I think in reviewing diagnoses, is highly desirable.

15 DR. DUPRE: I think we are zeroing in on 'which pathologist' in a very substantive sense, because of course I have taken Dr. Little's comments on the Barth study in this regard for what they are telling me, and this highly-experienced individual in compensation matters is of course telling us that there is a small population of either pathologists or clinicians who see a wide enough range of these diseases so as to be able to diagnose them with relative confidence.

THE WITNESS: Yes.

20 DR. DUPRE: So at this point the kind of pathologists that I have in mind when I ask my question about distinguishing various forms of pneumoconioses would be a pathologist who, I guess, would see a substantial volume of silicotic material, asbestotic material and whatever.

25 THE WITNESS: Then I think it's easy, fairly easy, with varying degrees of confidence, to diagnose certain pneumoconioses. The most simple is silicosis, because it has very characteristic lesions. That one is unlikely to be wrong in any of the usual manifestations of silicosis, though there are unusual manifestations of silicosis which turn up from time to time.

30 As I say, in my opinion asbestosis in its early stages is also a fairly characteristic lesion. I would not be able to say with confidence that a patient had this early form of

THE WITNESS: (cont'd.) asbestosis if, for example, he had been treated with chemotherapeutic agents that cause fibrosis of the lung. We don't have enough knowledge, really, as to what the chemotherapeutic agent does do to enable a firm statement.

But if you put those two aside and asbestosis, of course, also has its markers of asbestos bodies, then most of the other forms of pneumoconiosis cannot be diagnosed by just looking at the histological changes in the lungs, or for fibrosis, which is not characteristic.

Perhaps I should mention one further type of pneumoconiosis relevant in this province is the syenite miners near Peterborough. Since their dust does not cause any significant fibrosis in the lungs, you get the curious picture of men, with the lungs, interpreting gigantic quantities of dust really with very little disability whatsoever, and that one I could recognize as being different from the ordinary pneumoconiosis, and if I knew the patient came from here, that's probably what he had. If he came from other parts of the world, there are other inert dust exposures which give similar pictures.

MR. LASKIN: Go ahead, Dr. Mustard.

DR. MUSTARD: This little exchange raises a question. Let me pose a hypothetical problem.

A worker has engaged in the demolition industry and has had intermittent high levels of exposure to asbestos in that process, which he is unaware of. He smokes, and he comes down fifteen or twenty years after starting the demolition industry, deciding to live on a farm in a small Ontario community, he comes down with chronic chest disease. He's got chronic fibrosis of his lungs.

From the exchange we've had, there would be therefore a high probability that the linkage of his chronic chest disease to asbestos exposure might be completely missed?

THE WITNESS: Yes.

5 DR. MUSTARD: What kind of a diagnosis might he be given?

THE WITNESS: Again, you should ask Dr. Gray, but some sort of nondescript diagnosis of pulmonary fibrosis.

10 DR. MUSTARD: The question is then raised, and I realize this isn't related to the fibrosis thing, but one of the things that worries me a little bit - there's an aside in the cancer field - if you take the Doll and Peto estimate, their best estimate of the number of cancers that are occupationally induced, and you look at the number of claims the Workmen's Compensation Board gives for work-related cancer induction, it's a very interesting discrepancy which may mean Ontario is a far safer place than the rest of the world by a factor of about ten.

15 The thing that bothers me a little bit is that, therefore, there are people...there could be people in the population who had had asbestos exposure, who come down with chronic chest disease, who in fact never have it flagged or identified back into the process. Which, I guess, means that if a claim came in...and we were discussing this yesterday...in which the outside referring physicians had indicated some other kind of disease, that one should be very careful about accepting that outside opinion that indeed...and in fairness it probably should really be looked at by the experts to make sure that you get the maximum benefit to the persons putting in the claim, and being certain that you are digging out the probability that this is related to something like asbestos.

25 Is that a fair assumption?

30 THE WITNESS: I would agree, although I think the weakness in the line of argument is if the man is living in the country, he doesn't know that he has ever been exposed to asbestos, the clinician attending doesn't know either, the chance of the claim

THE WITNESS: (cont'd.) ever being placed is very low.

5 DR. MUSTARD: I was thinking of a claim that may
come in for some chronic chest disease, which may not identify
asbestosis, I suppose. I don't know whether that can occur or not,
but I guess really what I'm trying to say is, the difficulty of
the need for experts in this almost says that you need to have some
kind of information machinery there that gets the material in to the
10 experts so that they can then make the distinction.

THE WITNESS: Yes.

MR. LASKIN: Q. Are there any indices or markers,
either individually or in combination, which are specific to a
diagnosis of asbestosis?

15 THE WITNESS: A. Asbestosis means fibrosis of the
lungs caused by asbestos.

Q. Okay. I may not have put the question the
way I wanted, but looking at the situation, the pathologist going
in and diagnosing what a particular patient has or does not have,
are there any markers that that pathologist can be looking for
which will say to him specifically that this man has asbestosis
20 and doesn't have tuberculosis or some other pneumoconiosis?

A. Yes. As I said earlier, in my opinion the
changes, the kind of fibrosis you get in at least the early and
middle grades of asbestosis, are really quite characteristic.

25 Hence, if I saw some other kind of fibrosis in
the lung, that would be a negative character.

Secondly, I don't think one could reasonably make
a diagnosis of asbestosis without demonstrating asbestos bodies.

30 As I said earlier, always is never always in medicine.
This must be as close to being always as anything ever can be, so
you would have an appropriate type of fibrosis plus the presence
of asbestos bodies on the positive side.

Then as to the suggestion that it might be some other

5 A. (cont'd.) kind of disease, you have, of course, an immense variety of criteria of what the other kinds of diseases do.

If, for example, you found necrotic fossae which were filled with acid-fast bacilli, then the patient has got tuberculosis. Whether or not he has asbestosis, too, would then be a separate question.

10 If you find that he has the very different kinds of pulmonary disease which are produced, say, by viral pneumonia, he has got viral pneumonia and he doesn't have asbestosis.

So the criteria are in part that he must meet the pathological criteria for asbestosis, and that he not show the criteria which lead you to some other diagnosis.

15 DR. UFFEN: Can we go back to the silicosis for a minute? When a patient has silicosis, does that produce a fibrous condition in the lung, or some other condition that you wouldn't describe as fibrous?

20 THE WITNESS: Silicosis in its early and middle stages produces in the lungs a series of spheroidal fibrous nodules which are about three millimeters in diameter, and tend to arise along the course of blood vessels particularly, but also in other parts of the lungs.

25 If you imagine more or less scattering these things into the lungs, you might do with a pepper pot so they are randomly distributed, usually only in the upper part of the lungs.

DR. UFFEN: So it's quite different?

THE WITNESS: It's quite different from the broader fibrosis of asbestosis.

30 DR. UFFEN: This leads me to another question. Is it commonplace or rare to have a patient who has both silicosis and asbestosis?

THE WITNESS: Speaking without having looked at the

5 THE WITNESS: (cont'd.) data, most of the patients I have seen with asbestosis have also had silicosis...the exposure being likely to be to both in places like Johns-Manville plant, but not vice versa.

10 DR. UFFEN: And in the mines? They are both, they are silicates. One just happens to be a special silicate fiber. When you mine it, you grind up rock as well as ore. Have you ever heard of a case of a man who had developed silicosis from an asbestos mine, but did not have asbestosis?

THE WITNESS: There are so few people from asbestos mines that I've ever seen, since I don't see the material from Quebec, that I do not know.

15 DR. UFFEN: The dust would have two...there would be a very large amount of asbestos fibrous dust, and there would also be in some parts of the mine and mill very large amounts of just ordinary silicate dust. But you've not seen a case of one with silicosis, but not asbestosis?

THE WITNESS: No.

DR. UFFEN: From an asbestos setting?

20 THE WITNESS: Not that I recall.

DR. UFFEN: One final thing to tidy up. When you diagnose silicosis, does there have to have been a history of exposure to silicates, to put that label on it?

THE WITNESS: No. No, very often there is not.

25 MR. LASKIN: Q. Just to come back to your positive signs of asbestosis, and I think your evidence was that in the early and middle stages it's quite discernible to an experienced pathologist, that is experienced in that particular field, and can you elaborate on the kind of description? Can you elaborate on what you will see? Is one of the differences as between that and, for example, silicosis, the difference between rounded or
30 spherical nodules and irregular nodules?

5 THE WITNESS: A. As you look at it with the naked eye, the asbestosis lesions would likely to be multiple, ill-defined and according to the degree of the disease, of varying size...certainly not the very classic hard, round little nodules that you see in silicosis. You would not, by looking at the lung with the naked eye, be able to make a diagnosis of asbestosis. All you could say is that the patient has got some degree of pulmonary fibrosis of some sort.

10 It's only microscopically that the change gets some degree of...it gets characteristic features.

15 Microscopically, silicosis and asbestosis are entirely different. Here again, in silicosis, you see a...as you see it in a section...round nodule, which is made up of collagen which is very thick, it's got no cells, it's got a kind of woven pattern to it, as distinct from the very fine, delicate collagen with the normal number of cells that you see in asbestosis, so there is not the slightest difficulty in saying that you have, say, a carpet of asbestosis in the slide, with odd silicotic nodules scattered about in it. They are very different.

20 Q. One of our witnesses last summer suggested that with asbestosis you tend to see it pretty regularly in the lower part of the lungs as opposed to the upper part of the lungs. Does that accord with your own experience?

A. It does not. No.

Q. It does not?

25 A. In this, my experience is aberrant to the general accounts given in the literature. It's based, of course, as I've said many times, on a small number of cases.

MR. LASKIN: Dr. Mustard?

30 DR. MUSTARD: Can I just go back through this expert question? You may or may not recall in the Barth report on pages two, fourteen and two, fifteen, he poses the question of the dilemma about the cases of claims that come in that are

DR. MUSTARD: (cont'd.) referred to the advisory committee, and those that are not.

He gives the reader the impression that if the claim comes in and the external referring information suggests a diagnosis of asbestosis is not likely, the decision may be made not to transfer it to the committee, whereas if the diagnosis of asbestosis is made, it is put in.

One wonders if maybe...we would appreciate your views about his concern. I realize the administrative matters about that may make it not quite as black and white as it's put in the report, but I assume from what you said that you feel that for the sense of equity it all should be referred to the committee? If the claim is asbestosis?

THE WITNESS: Yes. I suppose sauce for the goose is sauce for the gander. If you do not read the reports one way, you should not accept them the other.

I think in practical terms here, a question of numbers should be considered. If, as I think is probably the case, there are very few claims for asbestosis, or relatively few, then the desirability of sending them to the committee, I think, is great.

If in fact there are a considerable number of claims and the committee's time would be wasted by looking at perfectly futile claims, then indeed there should be a screen with the criteria stated in some suitable fashion, which would not, indeed, include reliance on an opinion of some person of unknown weight.

Then the screen should be put it in.

DR. DUPRE: Can I just ask you this question, Dr. Ritchie? When you get cases referred to you and tissue material to examine, are you told that this is something involving an asbestosis claim or a silicosis claim?

THE WITNESS: Usually.

5 DR. DUPRE: Now, I ask you this - given the kind of experience you have, the variety of material you have seen, you would be able to tell the difference between asbestosis and silicosis, blind...

THE WITNESS: Yes.

10 DR. DUPRE: ...if you were not at all informed of what it's all about?

THE WITNESS: Yes.

DR. DUPRE: Okay.

MR. LASKIN: Q. When you get the case, do you also get any opinion from Dr. Stewart or Dr. Dyer, if he sends it, as to his own judgement?

15 THE WITNESS: A. Certainly not commonly. It's a rather factual kind of statement.

Q. Are you being asked solely to make a diagnosis, or are you also being asked in the event that you diagnose, say, asbestosis, to assess physical impairment?

20 A. The kind of opinion which I usually give has at least several bits to it. It makes a diagnosis of silicosis, and usually in these cases it's a rather flat-footed diagnosis. There may be occasions in which one has to give a variety of possible diagnoses that might meet the case.

25 Secondly, it assesses the severity of the disease as I measure it pathologically - mild, and in the case of silicosis, this is done relatively easily by merely counting the number of nodules, which gives you a rough measure of the involvement of the lung.

30 So the diagnosis and its severity...now, I may or may not give an opinion on whether or not this kind of disease might have caused some kind of effect, and that perhaps depends on whether

5 A. (cont'd.) I'm asked to do so or not, or whether I think that there is some particular reason for drawing attention to some possible effect of this particular disease.

Q. What are the categories of severity that you yourself utilize?

10 A. We divide the silicotics, this is, into four groups - those really who have got, I think the figure is less than ten nodules in a third of the lung, since I do it for different thirds since usually the bottom part has none and the top part has got all the disease - if they have less than ten, I call it one, and I would have to look up own table, as I need to do each time, to see...it's ten to twenty-five, I think, would be graded two, over that is graded three, and then in silicosis you also get
15 confluence of these nodules to form larger areas of fibrosis, and if this confluence is of minor degree...I think it comes in at two, if it gets greater the case automatically goes to three, and if it's massive we call it four.

20 DR. UFFEN: What are these twos, threes...are you about to ask that? The classification of two, three, four you are using.

THE WITNESS: This is the severity of the anatomical involvement of the lung by silicosis.

DR. UFFEN: That's not the same thing as reading an x-ray and classifying an x-ray by numbers?

25 THE WITNESS: Yes. These cases that I have classified in this fashion, morphologically, have had their x-rays read by Dr. Muir in Hamilton, who classified them according to the standard nomenclature for silicosis, and indeed as I was saying earlier, there is a surprisingly good correlation between the two measurements.

30 DR. UFFEN: That standard, is that an international standard, or what standard...

THE WITNESS: No. The morphological...the radiological one is an international standard.

DR. UFFEN: This other one isn't?

THE WITNESS: The morphological one we made up as being the appropriate degree of confidence you could have, to try and divide it into finer degrees of judging, I think, would be just to delude yourself.

MR. LASKIN: Q. What about asbestosis? Do you have similar categories?

THE WITNESS: A. No. Again, there are not enough of them.

Q. There are not enough cases come before you?

A. Not enough cases.

Q. But I take it, nonetheless, you still, when asked, do render an opinion as to the degree of severity of the asbestosis, morphologically?

A. Yes. Yes, this I do just in descriptive terms.

Again, let me point out what, of course, often seems to be overlooked - that I can only do this if the person dies. Since if you take a biopsy of a few cubic centimeters of lung, there is no way by looking at that that I can tell the extent of the disease in the rest of the lung. All I can assume is that the piece I've got is reasonably characteristic.

I certainly could make a diagnosis of the kind of disease, but then you must use x-rays or other criteria to determine whether the disease is extensive elsewhere. So it's only on autopsy lungs that you can get a morphological opinion as to severity which is very reliable.

Q. Are you ever asked by the Board to express any opinion on cause of death?

A. Yes. Sometimes.

Q. Are you...and does that include...would that

5 Q. (cont'd.) include cases where perhaps the claimant had a disability rating for asbestosis, and then passed away? Would the Board...would Dr. Stewart or Dr. Dyer seek your advice as to the cause of death?

10 A. This has happened occasionally. In the great majority of patients, they either die very clearly of the pneumoconiosis, or they die quite clearly of something else, and the question isn't really a very difficult one.

But there have been odd cases in which there was some considerable problem as to whether the pneumoconiosis may or may not have contributed to the patient's death.

15 I remember one patient who had a carcinoma of the thyroid, in which it was alleged that the appropriate surgery could not be undertaken because of the severity of the lung disease, which is a perfectly sensible, cogent suggestion. In this particular patient, the lung was not very severely damaged, and in my opinion and in other opinions I think that the Board sought, this was not supported...particularly, perhaps, as in this particular patient, it was rather questionable whether surgery was indicated anyway, in view of the nature of his disease.

20 Q. Are there any others of those kinds of cases that have been referred to, because, of course, one of the issues that we are concerned about is under what circumstances can you attribute, for compensation purposes, a death to asbestosis where the stated cause of death may be something other than asbestosis - maybe some other cause within the cardiovascular system?

25 A. Well, I thought...perhaps again, in parentheses, before answering that...that the quoted procedure in British Columbia whereby anybody with pneumoconiosis is compensated for any kind of cardiopulmonary death was stupid, since in fact I see no reason why a man with minor silicosis, who died of alcoholic

A. (cont'd.) myocarditis, should be compensated. Presumably he had had a happy life to achieve that end.

5 Equally, there is every reason to compensate somebody with severe pneumoconiosis who dies of cardiac failure secondary to the pneumoconiosis, so surely, in all equity, you have to show that the cause of death is related to the pneumoconiosis if you are going to compensate the patient.

10 I remember only one other case in which this question was asked, in which it was a question of whether a myocardial infarct was more likely because the patient had silicosis. The weight of evidence in the literature was perfectly clear, that there was no increased incidence of myocardial infarcts in people with mild and moderate degrees of silicosis.

15 I do not remember any other questionable relation between the cause of death and the pneumoconiosis. It's usually either yes or no.

20 Q. I take it you would not endorse the kind of scheme that apparently British Columbia now has in place to address this question?

A. No, I think it's unfair and unreasonable.

25 Q. Does any scheme make sense, other than looking at each individual case on its own merits? I mean, are there any particular causes of death within the cardiovascular system that can be related?

30 A. As I say, it usually is no problem, if you consider the asbestos diseases. If a man gets a mesothelioma and dies of it, it's clearly a compensatable cause. If he gets carcinoma and dies of it, it's a clearly compensatable cause. If he gets asbestosis and dies of respiratory failure or of cardiac failure of the kind that is caused by damage to the lung, it's clearly compensatable, and so on down the rest of the diseases.

So far as asbestos is concerned, I don't really

A. (cont'd.) see much problem.

5 There might be rare cases in which you had such a degree of asbestosis that you thought there was a possibly greater risk of myocardial ischemia due to coronary atherosclerosis, and there is a little piece in there...but they are very, very few.

Q. What about bronchopneumonia?

10 A. Again, it would depend on the extent of the fibrosis. Clearly, a man who has got extensive fibrosis would die of a relatively minor pneumonia that would not affect very much a healthy man.

Q. So it is possible...

A. That would be a sensible cause.

15 DR. MUSTARD: Let me just pursue this, both the coronary artery disease problem and the question of a pneumonia with chronic chest disease.

MR. LASKIN: I wish you would.

20 DR. MUSTARD: Obviously we can both agree that the extremes are clear. Where do you take the dividing point of this particular point?

Let me take the myocardial ischemia one, because that's one of my greatest biases. It's quite probable that one could argue that if you have sufficient narrowing of the coronary arteries, and sufficient impairment of the oxygenation of your blood, and increased stress situation, that you may precipitate abnormalities of the muscles in the heart, causing fatal
25 arrhythmia.

Now, it's obviously the nexus of a group of factors that came together. How can you ever sort that out in any kind of equitable manner as to which factor contributed which to it?

30 Obviously, if a person didn't have the coronary artery disease, of course it wouldn't have been present, but I can say with great confidence that all the males in this room have

5 DR. MUSTARD: (cont'd.) probably got reasonably good coronary artery disease. How can you sort out this problem? Is there any simple way to do it when you get into the murky ground of well, yes, it might be, when we get away from the extreme ends?

10 THE WITNESS: I think the only answer is if you do it epidemiologically. If in fact you can take, as you can do with people with silicosis, a relatively large population and find there is no excess of myocardial disease, then it's reasonable, I think, to assume that silicosis does not cause increased risk of myocardial ischemia in that population.

I know of no such reports of asbestos disease. Silicosis, of course, is a very punctate disease, so you can see it would have less effect than a more diffuse disease.

15 DR. MUSTARD: I see an additional problem in this in that it's not that the chronic chest disease is causing the underlying coronary artery disease, it's simply that it is a factor contributing the onset of symptoms which are going to perhaps occur anyhow. This may help them come on slightly earlier, or something like that, rather than being causal in the traditional sense of an epidemiological approach.

20 THE WITNESS: Yes, I don't think it could be causal in that sense. It can only be contributory to worsening the effect.

25 DR. MUSTARD: My dilemma is how you can ever come to a comfortable decision as to indeed it was never a contributing factor, versus the point where you might say the circumstances are as you describe - the severe chest disease, then obviously you could say yes, it could be a contributing factor to it.

30 THE WITNESS: I don't think there is any easy answer in all these sorts of questions. All you can do is consider the individual when you get this intermediate set of people, and do the best you can with the data available.

MR. LASKIN: Q. I suppose to ask a very layman's

5 Q. (cont'd.) type question in this area, but if you have one illness within you, say asbestosis or anything else, does it not generally tend to lower your defence mechanism or increase your susceptibility to contract other illnesses? In a very general sense? Or is it not that simple?

10 THE WITNESS: A. There is not an easy answer to that. It depends which disease, and certainly a relatively minor degree of asbestosis I don't think would affect anything. As it grows severe, then the answer becomes quite different. You are getting into a perilous state.

Q. There is a very grey area in between?

A. There is a grey area in between.

15 Q. Can I just ask you a few more questions on this, and I'm really looking at...there are a number of cases which have been brought to our attention, before the Board, where there has... it's a question of survivor benefit claims, and where the worker, who has since deceased, was on a partial disability rating for asbestosis, and a number of these claims have been rejected as death claims. I have already asked you about bronchial pneumonia, 20 which was one which recurred a number of times, in which the claim was rejected.

Another one I see here is coronary occlusion due to arteriosclerosis.

25 A. I think again I should qualify both those. The coronary sclerosis, I was just speaking in answer to Dr. Mustard's question.

Remember, that a very high proportion of people who die, die with bronchial pneumonia. It doesn't matter what you die of, you are likely to get some degree of pulmonary infection unless you die very quickly.

30 So bronchial pneumonia in the sense of a minor bronchial pneumonia that is an incidental part of dying is not very

A. (cont'd.) relevant.

What would be...bronchial pneumonia would only become relevant where the man had got sufficient injury to his lung that he had significant loss of pulmonary reserve, and had so extensive a pneumonia that it was fatal.

I should say in the absence of some other fatal disease which was a real cause of death.

Q. What about something like intestinal obstruction? Could there ever possibly be any relationship?

A. Not that I can see.

MR. LASKIN: Dr. Uffen?

DR. UFFEN: I was going to get onto a somewhat different subject, so I'll say what it is, because you may have had it in mind.

MR. LASKIN: No, you go ahead.

DR. UFFEN: Well, in Professor Barth's report, he talks for awhile, around about page two, twenty-three on, about a federal task force that examined the problems of lung illnesses.

It says: "A member of the task force is a consultant to the ACOCD."

Do you know who that was?

THE WITNESS: No, I do not.

DR. UFFEN: It wasn't you, then, eh?

MR. LASKIN: I think, to help you, it was Dr. Gray.

DR. UFFEN: It was Dr. Gray? Okay, thanks.

I didn't know that there was more than one consultant to the ACOCD. There are, then, more than one consultant.

There is a statement in here that I would like to ask you about. Have you got this thing, or shall I read it to you?

THE WITNESS: Yes.

DR. UFFEN: I'm looking at page two, twenty-four, the paragraph that starts out: "The task force placed considerable

DR. UFFEN: (cont'd.) "importance on the x-rays for identifying the presence of asbestosis.

Pulmonary function tests are also helpful in this regard."

Then: "The x-rays, however, are thought to be of no value in assessing the degree of impairment."

Can you instruct me on this? First of all, is it a sentence that you would agree with?

THE WITNESS: I think the answer had better come from Dr. Gray than from me. This is not within my area of knowledge.

DR. UFFEN: I see. You don't look at the x-rays, then? When you are asked to consult on a...

THE WITNESS: Yes, I very often do. Indeed, it's highly desirable that I do, since I can then look at whatever is in the...

DR. UFFEN: Then you look at them and presumably you figure they are worthwhile?

THE WITNESS: Yes.

DR. UFFEN: So I interpret it that you wouldn't agree with this statement: "The x-rays, however, are thought to be of no value in assessing degree of impairment"?

THE WITNESS: It would seem to me to be a little strong, but as I say, Dr. Gray has a better opinion than mine.

DR. UFFEN: We get tangled up in the interpretation of the word 'impairment'. As the medical consultant, what is your interpretation of impairment? If you are asked to assess impairment, what do you believe you are being asked to do?

THE WITNESS: Let me say first there is, in Professor Barth's report, a considerable confusion between impairment and disability.

DR. UFFEN: You have taken the words out of my mouth.

THE WITNESS: Unfortunately, the two words are

THE WITNESS: (cont'd.) used, in fact, synonymously, so that if you separate the meaning of impairment and disability, you must define your terms and your definition is really only good for your own statement.

If I were using them, and I would like to use some other words altogether, but can't think any...I would take impairment to mean a physical disability. If a person's vital capacity is reduced, that is an impairment.

Something that reduces his functional, physical operation, and I would sooner keep disability for something that reduced him in a more sociological sense - his earning power, his enjoyment of life in a negative sense, suffering in hospital, this kind of thing.

Those two matters, I think, should be always very sharply contrasted, since the impairment in physical function can be measured medically. The disability that that causes cannot. It's a sociological phenomenon.

Quite clearly if a pathologist loses one leg, it doesn't really cause him much disability in the sense that I have used....in the sociological sense.

But if a ballet dancer loses one leg, it's an entirely different story, though the impairment for those two people might be identical.

DR. DUPRE: I follow your distinction, Dr. Ritchie. My only confusion stems from the fact that I think that you expressed the opinion that Professor Barth had confused the two?

THE WITNESS: They are often confused. I don't know if he was confused.

DR. DUPRE: Oh, they are. Well, you see, he acknowledges that they are often confused. Then he goes on to make exactly, I think, the distinction that ...

THE WITNESS: His quotations are often very confusing.

DR. DUPRE: All right. Fine, thank you.

5 MR. LASKIN: I don't believe I have any more questions,
but in any event we are...I assume it's the lunch hour, so...

DR. DUPRE: May we then rise until the customary
two-fifteen?

MR. LASKIN: Is that all right, Dr. Ritchie?

THE WITNESS: Yes.

10 THE INQUIRY RECESSED

- - - - -

THE INQUIRY RESUMED

15 DR. DUPRE: May we, then, resume, please?
Mr. Starkman?

CROSS-EXAMINATION BY MR. STARKMAN

20 Q. Dr. Ritchie, this morning you were talking
about the distinction between impairment and disability. Just
so that I have it straight, when the Board sends you a specimen
for examination, you give them an opinion as to the degree of
impairment that this person might be suffering from?

A. Only in some cases. Let me give you a series
of examples to show what I mean.

25 If I have a biopsy sent to me which is a little,
small piece of tissue a centimeter or two across, it enables me
to tell what the disease is, to establish the diagnosis. But I
have no way of telling whether that particular biopsy is
representative of the disease in the rest of the lung. It could
be more than elsewhere, it could be less, it could be representative.

30 So in that case I can make a diagnosis, but can
give no estimate of the severity of whatever it is that I have
diagnosed. That must come on other grounds.

5 A. (cont'd.) If I have a lung...at autopsy have both lungs...I can then not only make a diagnosis of whatever, but can determine the severity of the involvement of the lungs in an anatomic sense.

10 Now, that may or may not enable me to estimate the degree of impairment. Obviously at the two limits it's very easy to do so. In the middle it may be impossible, and particularly in people with silicosis.

15 Q. But the medical examination, if someone was to be examined by the advisory committee, they would be making the recommendation or the finding as to the degree of impairment?

A. That's right.

20 Q. And the disability is something which is not really in the medical field?

A. Yes. That is using those terms in the sense as I defined them this morning.

25 Q. So we would properly, then, look to the Workmen's Compensation Board in this case, to make a determination, or to look to the degree of disability?

30 A. Yes.

Q. I am not that familiar with medical practice. A biopsy, is that a complicated procedure at this time? To obtain the specimen?

35 A. Not now, if one is thinking specifically of...of course it depends where you take the biopsy from...if you take it from your skin, of course, it's a trivial procedure.

Q. But a lung biopsy?

40 A. But a lung biopsy is now not to be undertaken lightly, but is no longer the major process it used to be. It can be done quite safely and quickly.

45 Q. So would it be, in terms of taking a lung biopsy of the persons working in an asbestos environment, would that be a

Q. (cont'd.) feasible procedure?

5 A. It's perfectly feasible from a point of view of taking the biopsy. Whether it would be desirable and justifiable to subject the person to a biopsy for this purpose is a matter which would have to depend on the medical judgement of the nature of his disease at the time.

Q. So there's potential medical complications?

10 A. Yes. It's a safe procedure, but nothing is ever perfectly safe, so it should never be done unnecessarily. One commonly takes lung biopsies in patients with fibrosis of the lung in an attempt to establish the diagnosis on medical grounds, without any thought of compensation. There have been a few patients who have had a biopsy, it appeared, to establish the nature of
15 the disease really with an idea as to whether it was compensatable or not.

That's rather an unusual reason. The vast majority of biopsies should be done because it was necessary for the management of the patient.

20 Q. I guess what I was thinking of is if someone had deteriorating x-rays...had x-rays taken, something showed on the x-rays, but it was unclear as to what it was, what the extent of the...

A. In this case, a biopsy might...

Q. Would that justify a biopsy?

25 A. This sort of circumstance would justify it. I suppose basically if the biopsy likely or might show something which will help in the treatment of the patients.

30 Q. I'm a little unclear as to what role you would play with the advisory committee. I say that because Dr. Vingilis was here, and when we asked him about who was on the advisory committee he mentioned your name and he seemed to mention, as I

5 Q. (cont'd.) recall, that they would have periodic meetings with you or consultations with you over specific cases that had been referred to them. Is that how it would work?

A. This has happened occasionally. As I say, my normal relationship is rather that the Board asks me something or sends me some material for examination, and I report to the Board, usually through Dr. Stewart.

10 Now, I assume that those reports are forwarded to the advisory committee for their consideration. I'm sure this is the case. That's what usually happens.

15 There have been a few occasions on which I have met with members of the advisory committee, usually to consider patients in which there was some difference between our opinions, or something of the kind, and I think it would be fair to say the principal purpose was to make sure that we were clearly understanding, at least the committee was clearly understanding what I was saying. I don't hear what they say.

20 Q. In cases where there's differing opinions, I think Dr. Vingilis suggested that there were times when the advisory committee might disagree as to the proper diagnosis, I guess what I'm concerned about is in the evidence that I've heard, the diagnosis of asbestosis is a difficult procedure...

A. Not pathologically.

Q. Not difficult, but...

25 A. No, if you take a biopsy which shows asbestosis, it's usually not a difficult diagnosis.

Q. But if you don't have a biopsy, and you are talking about whether someone has asbestosis?

30 A. Then I think you should refer the question to Dr. Gray, as to what the clinical criteria for the diagnosis of asbestosis are.

Q. I understand that, but what I'm getting at is

5 Q. (cont'd.) if, even amongst people who are of some experience in making these diagnoses, such as those on the advisory committee, if there is disagreement between them as to whether someone is asbestotic or what the extent or nature of their disease is, what conclusion is a layman to draw from that situation? In other words, disagreement among experts as to the extent or nature of someone's illness?

10 A. It's a difficult question to answer simply, because this is a matter in all medical judgements. As I said before this morning, there are some that are clear this way and there's some that are clear negatives, and you have some in the middle, and there are various kinds of reasons why you may not be able to make an altogether clear diagnosis, or you may be able only to make a partial diagnosis. For example, to decide on good
15 clinical grounds that the patient has fibrosis of the lung, but not be able to suggest a cause.

You may have reason to suggest one, two or three causes, all of which are quite possible on the data available, and certainly in this kind of patient you may well do a biopsy to see
20 if you can distinguish between those causes histologically.

Q. I guess to put a more concrete example, if there was a disagreement that there was a diagnosis which everyone agreed on, but there was a question as to the extent of the impairment, couldn't decide if it was ten percent, forty percent or whatever the numbers would be, if there was disagreement among
25 the experts, how would this...I mean, how is a layman who would be aware, let's say, of this disagreement, to resolve that difference? Or how would the experts themselves resolve that difference in the normal course?

30 A. Again, it's a question, really a basic one of medical practice. I think if you are thinking of impairment of pulmonary function, again, as Dr. Gray will be able to tell you,

5 A. (cont'd.) the methods available for testing that are now very good, and these are to a very large degree, objective.

There are other more subjective aspects to this certainly, but basically that's a fairly firm opinion.

The disagreement is less likely, I think, to be about the degree of impairment than perhaps, in a difficult case, the nature of the disease.

10 Q. If there is disagreement as to the nature of the disease, how would that be resolved? If there is disagreement among, let's say, the doctors on the advisory committee?

15 A. Again, I cannot speak for the advisory committee because I have no experience of their proceedings under such a circumstance. The normal behaviour medically is certainly after seeking the best advice you can, and exhausting the various methods of investigation you can, you must make the most practical decision possible on those grounds.

Q. When you say 'practical decision', what...?

20 A. In practice it's usually the thing that will be best for whoever has got the disease.

Q. I'm a little unclear as to if someone is diagnosed as asbestotic and they die, subsequently die, what is the...what would the cause of death be, medically speaking?

25 A. Again, there is not a simple answer, since a patient can have asbestosis, but to a very mild degree, really causing him no harm whatsoever, and then he has the same risk of dying of anything that the general population does.

30 You can pass from that to people with asbestosis who have major fibrosis of the lungs, and are likely to die of the impairment of pulmonary function caused by the fibrosis, and in between, of course, you have people who are partially impaired insofar as their pulmonary function is concerned, and hence more

5 A. (cont'd.) at risk if they get any other disease which impairs pulmonary function. Then overriding that, you have the high risk of carcinoma of the lung in people with asbestosis, which is a different kind of risk.

10 Q. I guess what I...if someone has severe fibrosis in their lungs, that itself doesn't kill them, as I understand it. Something else is the...happens which results in the death. Is that...

15 A. The fibrosis itself can kill them in several ways. It, itself, can grow so severe that the pulmonary function becomes inadequate.

Now, if this is happening you usually add something else on at the end, a little infection or something, but that can happen.

20 There was a patient who died in the Toronto General Hospital, not with asbestosis but with a different kind of pulmonary fibrosis, a few days ago. In this case the strain on the right side of the heart, which pumps the blood into the lungs, was so great that instead of having the left side of the heart making up seven-eighths of its substance and the right one-eighth, the proportions were almost reversed, and you can understand that an immense strain, therefore, on the right side of the heart, and this patient died of right-heart failure - clearly secondary to the disease in the lungs.

25 So these mechanisms of death can occur if asbestosis is very severe.

Q. If someone has severe asbestosis, what I'm trying to get clear is, they die because their heart fails or they die because they have a stroke?

30 A. There would be no particular reason why they should. If they died directly of the asbestosis, the things would

5 A. (cont'd.) be failure of pulmonary function, perhaps more probably failure of cardiac function, and always with asbestosis the very high risk of carcinoma of the lung.

MR. STARKMAN: Those are my questions.

DR. DUPRE: Thank you, Mr. Starkman.

Mr. McCombie?

10 MR. MCCOMBIE: I just have a couple of questions, Dr. Ritchie.

CROSS-EXAMINATION BY MR. MCCOMBIE

15 Q. One area that I'm somewhat interested in, and I'm not sure if it's appropriate for you to comment on it, but throughout a lot of your testimony this morning you were indicating that throughout the province the pathologists, the general population of pathologists, have a lot of problems with differentiating between the different kinds of fibroses, and that there is a need for a strict training, if you like, in the area of industrial identification of industrial fibroses. Is that a fair comment?

20 A. Yes. It's not quite what I said. I said that most pathologists see so little industrial disease that they are not skilled in its interpretation, and unless it's suggested to them, they may not even think of it as a probable cause.

25 You brought a second question - the diagnosis of pulmonary fibrosis. Now, there are a great many causes of pulmonary fibrosis, and often a major problem in medicine is to try and decide the cause of that. That can be a very difficult problem both clinically and pathologically.

But that, without any relation to industrial disease, these patients have other kinds and other causes of pulmonary fibrosis.

30 Q. I guess what I'm trying to get at, and perhaps in light of your experience as a professor at the University of

Q. (cont'd.) Toronto...that's correct?

A. Yes.

5 Q. I'm wondering if you have any comments on the training of doctors, and I guess pathologists in particular, with respect to recognition of industrial disease in general, and I guess fibrosis in particular?

10 It seems to be a big problem not only in the question of asbestos disease, but in general as far as industrial disease goes, that there is a real dearth of specialists in the field, and I'm just wondering if you have any comments on that, whether that's what the reasons for that are or whether that is changing, whatever comments you have on that.

15 A. Well, things are certainly changing greatly in that a much greater proportion of disease these days is caused by not necessarily industrial agents, but all sorts of drugs which have adverse reactions, the whole variety of manmade causes of this sort, and while I think if you were training in pathology or anything else twenty or thirty years ago, these were really infinitesimal, there were very few cases of the kinds recognized.
20 Many of the more dangerous agents had not been introduced, or the dangers they caused had not yet been widely recognized, so it was very small.

So the general interest in artificially-caused injuries has risen very greatly.

25 Now, having said that, the proportion of those that are industrial injuries remains very small, if you consider the whole gamut of material necessary to be learned by a pathologist. This is a very small piece.

30 In the training, it would not be reasonable to give any very great emphasis to that in the time available, as concerned with, say, the diagnosis of carcinoma of the breast, which is a very common disease.

5 A. (cont'd.) This, I think, is the problem with the industrial disease - unless you have a specific interest in them, unless you in some fashion artificially concentrate their numbers, there is not enough of them to see them frequently enough to gain expertise.

10 The same, I think, is true if you consider training in internal medicine. If you have to cover in your training the whole gamut of the subject, this piece must be a very small one.

15 Q. Given that though, would it be fair to say that you would be more inclined to, in your own teaching, at least give some recognition to industrial diseases, more so than I guess yourself received? Has it changed to that extent that at least it is recognized?

20 A. This is true, and certainly there is a considerable emphasis now, as I said, on diseases caused by various artificial agents. But the industrial part still remains a very small part of the disease.

25 Perhaps I should say if I considered a man training in pathology in the Toronto General Hospital, who was there for the usual four or five years, he probably would see a few patients that had silicosis. These would probably be with involvement only of lymph nodes, without any pulmonary disease, without probably any industrial exposure. And these he should be sufficiently familiar with to recognize.

30 Whether he would be sufficiently familiar to be sure it was silicosis and not something else which can produce a similar lesion is perhaps something else, and he might prefer to get a further opinion on such a patient, if it was relevant.

35 But I would doubt if he would see any patients with asbestosis. He would certainly, in the particular case of the Toronto General, see mesotheliomas. But that's really only because I happen to have them referred to me.

A. (cont'd.) If you take away those, you probably would not. I doubt if we would get one in four years.

5 Q. I guess the bottom line to all this is that at least in the foreseeable future there is going to continue to be very few people in certain specialty fields that will have the expert knowledge on certain industrial diseases, or occupational diseases?

10 A. Yes, I think this is necessarily so. Indeed, the number should, in my opinion, be kept low in that if you are going to be familiar with anything - it doesn't matter whether it's industrial diseases or mending a motorcycle - you must have a sufficient number of cases that you see on a regular basis in order to remain proficient at whatever you are doing, and I think
15 it's the same in industrial medicine. You need some concentration of cases to get skill.

20 Q. The other area that I'm interested in is the whole question of autopsying. I believe...I can't remember the number off the top of my head...but I believe Professor Barth indicates that there is a fairly low number of autopsies that are routinely done in Ontario, and certainly one of the questions that I have for others is, and I put it to you, is do you see any mechanism for...first of all I should preface this by asking that I gather you see this as a useful tool, is that correct?

A. Yes.

25 Q. Do you see any way of increasing that number, or is this something you have ever discussed with the ACOD or the Compensation Board as far as people that are currently receiving benefits, let's say for asbestosis? Has there ever been any kind of mechanism discussed to routinely get autopsies performed on those claimants?

30 A. Perhaps just more generally, I think in thinking of autopsies they have many virtues. Perhaps the principal and

5 A. (cont'd.) major virtue they have is they in fact determine whether the medical care given was in fact properly directed, whether the diagnoses were right, and this is irrespective of industrial disease or anything else.

10 But as applied to industrial disease, asbestosis and silicosis being the two principal ones here, I think autopsies should be recommended very strongly to anybody who might possibly be involved, because my experience has been very clear that though I quite often will find evidence, say of silicosis, in a patient who is thought not to have silicosis - raising the possibility of his being compensatable, though it is true that the degree is not likely to be great and the compensation may be limited - but nevertheless it is an advantage of the family of the man concerned.

15 So if you take this view, that an autopsy is of virtue to workmen or workmen's families, if they are in a position in which they may suffer an industrial injury, the question then comes as to how best should this be made known to them, and by whom.

20 While I think the Board should do anything it can, this is in fact a very delicate matter. Nobody much cares if somebody rushes up to them and says, here's a piece of paper, will you sign it so you can have an autopsy when you happen to die. So it needs to be done very delicately, and my own thought is for the optimum body to give this information to the workman is probably their union, who is an organization of their own and can assess the matters and deal with them in an appropriate fashion.

25 Q. Although that leaves out a large segment of the work force that is nonunionized?

30 A. Yes, this does, and hence one must look to other matters. It's a continuing problem. One can readily point out the virtues of autopsies under all sorts of circumstances, and yet it is an awkward procedure to carry out. It is particularly awkward in Ontario, where the usual custom...and I'm not sure if

5 A. (cont'd.) this is now legally binding or legally required...is that you cannot perform an autopsy unless you obtain the permission of the next of kin, which must be the next of kin, immediately after the patient dies.

As you can well see, this is no very good time to be rushing up and making such requests. It is very awkward.

10 But there it is, and it has to be done by that fashion, unless my interpretation of the Human Tissues Act would in fact enable the person to agree to his own autopsy. I have never asked for legal advice on whether that is right or not.

15 The practice is, it's done by seeking permission of the next of kin, and hence that's where you would have to give the information and you would have, sometime before the patient was severely ill preferably, have given them the information on which to make a judgement.

20 It is perhaps noteworthy that the number of autopsies on miners that come from Timmins is very high, and clearly some information service is operating there, and quite often the autopsies from that area are requested by the miner's family.

25 Q. Would you see a benefit in, for example, doing either the Compensation Board or some other body, routinely sending out notices...for example, you mentioned unions, but in nonunion situations to the family physicians indicating that an autopsy in this particular case...and you say they are generally a good idea, but in the case of occupational disease may in fact be a good idea?

30 A. It would be easy to do, I would think, for the number of physicians concerned in the areas in which you find the greatest majority of miners, and while I wouldn't be very hopeful that it would do very much good, it certainly wouldn't do any harm.

Q. Have you ever been involved in discussions with this problem, with the Compensation Board or the ACOCD?

A. No.

Q. Just one final thing which quite frankly I am a little bit in the dark on, and that is your role vis a vis the ACOCD. It seems somewhat complicated to figure out exactly who is on and who is sort of on and who is not on at all, the ACOCD. I'm just wondering if you clarify whether you are in fact a member of the ACOCD, a consultant to them, or what your position is.

A. I think I would define my function as being consultant to the Board.

Q. Consultant to the Workmen's Compensation Board?

A. And not specifically to the committee. Though, as I said earlier, I assume it's the committee that evaluates my reports in those cases that are seen by them.

DR. UFFEN: Could I just...

MR. McCOMBIE: Sure.

DR. UFFEN: If you are a consultant, then presumably you have a contract?

THE WITNESS: No, sir.

DR. UFFEN: You have no contract?

THE WITNESS: No.

DR. UFFEN: Do they call you on an ad hoc basis?

THE WITNESS: I don't think I have a contract with anybody for anything.

DR. UFFEN: Not even the U of T?

THE WITNESS: Not even the University.

DR. UFFEN: But you just get called on an ad hoc basis, without any retainer then?

THE WITNESS: Yes. I'm paid a fee every time I look at a case.

DR. UFFEN: I'm not curious about the size of it or anything, just to pursue this, you don't have a retainer?

THE WITNESS: No.

DR. UFFEN: I see.

Why I was asking was, because whoever writes the invitation to you, then, is presumably the person who is employing your professional services?

THE WITNESS: Yes.

DR. UFFEN: Who writes you the letter and invites you?

THE WITNESS: Various people. Usually Dr. Stewart, sometimes Dr. Vingilis, sometimes Dr. Dyer. They would be the principal people.

DR. UFFEN: Do you mind if I pursue that? None of them are at the Board.

MR. McCOMBIE: Dr. Stewart.

DR. UFFEN: Dr. Stewart is an employee of the Board. When you use the word Board, you mean the Board and its employees?

THE WITNESS: And its...yes.

DR. UFFEN: All right. Now, Dr. Vingilis...have I got his name pronounced right...he is not...he was an employee of the Ministry of Labour. Did you get invitations for your professional services from him when he was a member of the staff of the Ministry of Labour?

THE WITNESS: I'm afraid I have never read what Dr. Vingilis signed himself as when he signed these letters. From my point of view, I have always taken these various signatories as being precisely the same, and irrespective of who asks me about the case, I send the report to Dr. Stewart, and of course to whoever signed the letter.

DR. UFFEN: I think perhaps you can appreciate then why some of us have difficulty sorting out the roles when the invitation for your services seems to come in a way that is difficult to nail down.

THE WITNESS: I'm afraid I cannot clarify that for you.

DR. UFFEN: Sorry to interrupt.

MR. McCOMBIE: That's all right.

Q. Maybe just one other question in this regard, then, and I don't know if this would help us, but you are paid for these services. Who would pay you? Who is the cheque from?

THE WITNESS: A. The Compensation Board.

Q. So that would be regardless of who...

A. Regardless of who initiated the inquiry.

Q. The cheque comes from the Compensation Board?

A. Yes.

MR. McCOMBIE: Okay, thank you. That's all I have.

DR. DUPRE: Just to put the icing on Mr. McCombie's cake and your reply to it, Dr. Ritchie, on page four, two Professor Barth describes the ACOCD as having five members, and then the following sentence reads:

"In addition to the five members, there are three consultants who meet with the panel."

Those are Barth's exact words.

Now, I take it that...I always have been understanding them differently. You have three consultants who meet with the panel, but in your case in any event, you are a consultant to the Board, not a consultant to the ACOCD?

THE WITNESS: Yes, this is right. And certainly on the occasions which I have met with the committee, it has not been to consider anybody's claim, but for a general discussion on appropriate things.

DR. DUPRE: Miss Jolley?

MISS JOLLEY: Yes.

5 CROSS-EXAMINATION BY MISS JOLLEY

Q. I would like to pursue...we were discussing this morning the misdiagnosis by general physicians of asbestosis... but I would like to pursue the misdiagnosis of mesothelioma.

10 In your experience, is there a great deal of misdiagnosis of mesothelioma? I suppose there isn't a great deal of mesotheliomas.

A. There's not a great deal of mesotheliomas.

15 It's very difficult to ask. Mesotheliomas seem to have become considerably more common. Now, the value of that statement should be very much questioned, since the number of mesotheliomas that I see becomes more common, because they are referred to me, so it is not a reasonable judgement as to frequency of the disease.

20 But still, the number that are referred seems to be increasing.

25 Until quite recently, it was almost held that it was impossible to make a diagnosis of mesothelioma until the patient died, and you determined at autopsy that he hadn't got any other tumor.

Well, I think we have regressed or advanced a little bit from that, and are now reasonably willing to make a diagnosis of mesothelioma. But it still is, speaking pathologically, a difficult diagnosis, and if we confine ourselves to the diffuse mesotheliomas which are the fatal tumors, and ignore the less dangerous local ones, the diagnosis should always be made on a combination of factors.

30 One predominant one is certainly the histological appearance, which is the one most readily available to me, and

A. (cont'd.) that can be ambiguous.

At times it is highly suggestive, so you would be...
5 if I could put it roughly into a figure...ninety-five percent
certain that it was a mesothelioma. Never quite...at times you
might be in very considerable doubt, and the question is between
a mesothelioma and some other kind of malignant tumor.

Now, that is very difficult. I would be quite
10 willing to believe that in past years people have tended to make
a diagnosis of anything else than mesothelioma, because it was
the custom of the times. Now we are beginning to separate them
out more clearly.

Even granted that by now I've seen a lot of them,
there are a sizeable number of cases in which I have not indeed been
15 sure - not even indeed sure in the sense that I would like the
patient's treatment to be based on the hypothesis that he has
got a mesothelioma, as a reasonable opinion under the circumstances.

It is in these patients, just as I was mentioning
earlier, particularly electron microscopy is a useful diagnostic
20 procedure. So it's a difficult diagnosis.

Q. We have had evidence before the Commission
the last year, and certainly Muriel Newhouse's studies indicated
that pancreatic cancer was in fact a cancer that was often
identified rather than mesothelioma, and would it make sense...is
that your experience as well?

A. It can be of considerable problem. There is one
25 case in particular I remember, in which even at autopsy the nature
of the tumor was very difficult to determine...the two possibilities
being, in fact, mesothelioma and carcinoma of the pancreas.

So it's not the carcinoma that I would have chosen
as being the most likely to cause confusion.

Q. In the cases of an asbestos worker diagnosed
30 as, for example, dying of pancreatic cancer or...what would be

Q. (cont'd.) the most likely misdiagnosis that you would suggest?

A. Dying of carcinoma of the pancreas?

Q. Well, the most likely misdiagnosis of mesothelioma, in your experience?

A. I think we are perhaps getting confused. Carcinoma of the pancreas is usually a very simple diagnosis.

Q. Right.

A. There are certain technical problems in making it, but once you have made it, it's a clear and unequivocal diagnosis.

Q. But there have been suggestions...

A. But there have been a very few cases in which there has been some question as to whether the patient had a carcinoma of the pancreas spreading out over the peritoneal cavity like a mesothelioma, which is a very odd thing for a carcinoma of the pancreas to do...or whether it is a mesothelioma that has grown further into the pancreas than is usual, which is not a very uncommon thing for mesothelioma to do.

In rare cases, I can only think of one, that was a problem. Usually when you have a problem as to whether the patient has got carcinoma or mesothelioma, the carcinoma you are thinking of is carcinoma of the lung or carcinoma of the kidney, both of which can mimic this kind of growth relatively easily.

Q. You suggested this morning in the case of the asbestosis that some effort ought to...rather than the claim stopping with the family physician deciding that in fact there is no indication of asbestosis...that perhaps some of these cancers ought to be taken forward as well, and perhaps sent to you for further investigation, because of that potential problem of misdiagnosis?

A. This has been done occasionally, in patients

5 A. (cont'd.) with carcinoma of the lung, particularly, in which there was a suggestion of exposure to asbestos which had not been substantiated, and certainly there is the question of confirming the diagnosis of carcinoma of the lung. That's not usually any problem or raises any question.

10 The thing that can sometimes be done is to discover in the tissue removed evidence of asbestos exposure, and this can be done and is often not done at the time the surgery is performed where there may be no suggestion of asbestos disease, to the knowledge of the surgeon or the pathologist involved at the time.

15 Q. I think that...I mean my concern is yet again that there may be underestimation or undercompensation because other physicians are misdiagnosing the situation.

20 A. I fear that this is the case. I think once the case has reached the Board, or has been referred to me, then any fault is certainly the other way. We tend to read very lightly that it is a compensatable disease, and give the benefit to the person concerned.

25 But if the claim is never initiated, of course it never gets anywhere.

30 Q. Perhaps the Board could initiate communications with physicians yet again about that potential as well. Would that make sense?

35 A. I am very much in favor of getting as much publicity as possible to the right people, if you can do it without raising all the foolishness raised by the Globe and Mail and most of its unjustified medical reports, so that they really get a realistic idea of what is compensatable and what isn't compensatable, and perhaps more importantly what risks they run and how they can best be avoided, and things of this sort.

40 I'm not competent to suggest how this should best be done, and whether the Board is the appropriate agent, which it

5 A. (cont'd.) may well be, or whether there is some other mechanism which might be better, or whether some combination of mechanisms should be introduced. This I'm not competent to say.

Q. I would like to go on to...you mentioned this morning the fact that after you had done the study for the Board in the middle-seventies, that perhaps there was no need to further research until perhaps now, we might look back.

10 We've had evidence last summer about lymphomas being connected with exposure to asbestos, a significant increase in lymphomas in one or two studies, and similarly Selikoff's most recent studies have produced a significant increase in kidney cancer.

15 Do you think that it would be worth taking a look at those two?

A. I think in the case of the lymphomas, no.

20 While I haven't looked for specifically for literature about asbestos and lymphomas, in the last couple of years, I did something like that ago (sic), and thought that the association was really nonexistent at that time. This, I think, has been agreed to by other people.

I am unaware of the paper about the kidney. Again, it would surprise me a little bit if it were a good association because of Selikoff's own earlier work in which, in spite of his very detailed studies, he had not revealed that.

25 If it was true, then it should be considered.

Q. It was in his most recent, and in fact it was part of the material sent about laryngeal cancer, to the Board.

30 Just a last question, and that is about the laryngeal cancer, because the Tony Miller study flowed from your recommendation for further study. What came out of that, and I don't think there has been a final report - have you seen a final report?

A. I have not seen one, no.

5 Q. No. The actual guidelines that flowed from Dr. Miller's analysis link asbestos and nickel, and in your reviewing of the literature was this linkage...

A. No, it was not.

Q. Do you know where that linkage came from, other than the fact that that case came out of International Nickel?

10 A. No, I do not. I took almost no part in this study and know very little about it.

MISS JOLLEY: Thank you very much. Those are all my questions.

DR. DUPRE: Thank you, Miss Jolley.

Mr. Edwards?

15 MR. EDWARDS: I have no questions, thank you, Mr. Chairman.

DR. DUPRE: Dr. Uffen?

DR. UFFEN: I haven't any.

20 DR. DUPRE: Just one last question, if I might, Dr. Ritchie, I think the answer has already been implied in your dialogue with Mr. McCombie, but I just note that on page nine, twenty Professor Barth makes the following point:

"One possible way for the WCB to assess the work of the ACOCD is to autopsy as many deceased asbestosis claimants as possible, and view the findings in the light of the WCB ratings.

25 Essentially the study would review how the recent ACOCD decisions compared with the condition of the lungs at the time of autopsy. It could examine the lungs for the presence of asbestos fibers as well. Such a study would not be undertaken with a view towards changing awards; instead, it would serve to assist the Board doctors and the ACOCD

30

DR. DUPRE: (cont'd.) "in making future decisions."

I always like to run the musings of professors of economics past professors of pathology when they are trespassing outside their own field. What is your reaction to Professor Barth's description here?

THE WITNESS: I would agree strongly.

Perhaps I could say, again without any relation to occupational disease, that over many, many years numbers of studies in every...I should not say every...in a great many countries, including Canada, have shown that if you choose in major hospitals where one would expect a high standard of practice...I should put that more positively than that...in which there is a high standard of practice...that if you compare the clinical findings and the clinical diagnoses, and the findings at autopsy, there is in something like seven percent of the patients a major discrepancy, where a major discrepancy is defined as something which would have altered the treatment of the patient - excluding, for example, if you find a carcinoma that hadn't done anything, or something of this sort - but something which might have changed the care of the patient.

Now, I see no reason to think that any other population is going to be any better, and certainly whether it is the council or anything else, it would be helpful to confirm their findings by this means.

In particular, it should be possible, if one were able to carry out a sufficient study of this sort, to refine the criteria used, and to improve the quality of the service overall.

DR. DUPRE: Mr. Laskin?

MR. LASKIN: I have no further questions, Mr. Chairman.

DR. DUPRE: Dr. Ritchie, indeed Professor Ritchie, may I thank you most sincerely for sharing your knowledge with us, and indeed for contributing to our education in a very major way.

DR. DUPRE: (cont'd.) Thank you, sir.

MR. LASKIN: Thank you very much, Dr. Ritchie.

THE WITNESS: Thank you.

---the witness retired

DR. DUPRE: Well, counsel, is it your view that we should break at this time, and that Mr....is Mr. McDonald due back?

MR. LASKIN: He is at the Board, if you wish him. I'm really in the Commissioners' hands and the parties' hands as to what we want to do.

DR. DUPRE: Well, one inclination that I have is to just talk to my colleagues here for a moment.

Counsel, could I ask you to come here for a moment, please?

MR. LASKIN: Sure.

DR. DUPRE: The Commission proposes to resume as soon as Mr. McDonald can make his way down. That should be about quarter to four, I would imagine, and then we would go until about quarter to six, and not let grass grow under our feet, so to speak.

THE INQUIRY RECESSED

- - - - -

THE INQUIRY RESUMED

DR. DUPRE: Well, may we resume?

Mr. McDonald, welcome back. Thank you for accommodating our schedule.

THE WITNESS: No problem.

JOHN McDONALD, PREVIOUSLY SWORN, RESUMES THE WITNESS STAND

DR. DUPRE: Counsel, you wish me to go to the batting order, I understand?

5 MR. LASKIN: I still have some more questions, but I believe Mr. Starkman has got some time problems tomorrow, so I think it would be appropriate at least to be able to examine Mr. McDonald now.

DR. DUPRE: If you please, Mr. Starkman.

MR. STARKMAN: Thank you, Mr. Chairman.

CROSS-EXAMINATION BY MR. STARKMAN

10 Q. Mr. McDonald, the other day you provided us with a copy of the Board's recent policy on file access.

A. Yes, sir.

Q. Is that a final...is that policy in effect and final, or is it under consideration?

15 A. It's under review at the present time, but it is active and has been active since the day it was announced, and that was December 28th, I believe it came into effect on that date. But it is subject to further review, but there would not be any lessening of the present access.

20 The issue that the Board was asked to consider, in part, was that relating to summaries of information. Some of the representatives asked that the old practice of summaries be continued, in addition to providing full access to the file.

They found that they had to work in going through the file, rather than referring to the summary.

25 I'm not saying that for all representatives, but certainly in some instances they found it much easier to use the summary of information.

Q. Was this new policy, this dramatically changed policy, was that a response to Weiler's recommendations in the White Paper?

30 A. In part a response to Weiler, and a response to Krever and Williams, the whole combination of things, and the

5 A. (cont'd.) chairman had made a commitment before the standing committee on resource development...I'm not sure if it was the resource development at that point in time...that the decision would be made regarding access, prior to the end of 1981.

DR. DUPRE: Mr. Starkman, could I just ask one question for clarification?

10 Yesterday, you may recall, Mr. McDonald, we got into some confusion over another document that was put before us. This was the document where the heading read, Procedural Guidelines for Claims Adjudicators - Asbestosis, and it turned out that this document was one that was part of the submission for our education, not a document that was actually given to adjudicators.

15 Now, with respect to the document on which Mr. Starkman is asking questions - namely, the policy statement of access to the workers' claim files, is this a document that was...

THE WITNESS: Released to the public, sir.

DR. DUPRE: No, this was...

20 THE WITNESS: It was not prepared for you, sir. It's a general document that is in use. Yes.

DR. DUPRE: Thank you.

Thank you, Mr. Starkman. I just wanted to make sure of that.

25 MR. STARKMAN: Q. Now, as I understand this policy now, it's that the claimant or their representative would be allowed access to the file if there is some issue in dispute?

THE WITNESS: A. Yes, sir.

Q. For an issue to be in dispute, does it have to be actively appealed, or is it just a matter of...

30 A. If the claims review branch had made a decision to deny any part of entitlement and the individual wishes to pursue that through the appeal system, he can at that point in time request access to his file and a copy of the file.

5 Q. But does he have to indicate that he is appealing before he has access to the file, or does he have access to the file in order to determine if he wants to appeal?

A. If he wants to appeal. In other words, he would go ahead with the appeal following a review of that document. It's an either/or situation.

Q. All right.

10 Now other than what is outlined here with respect to the claimant and the employer under the circumstances set out, I understand there are other people who routinely have access to the WCB files, that doesn't seem to be represented in the policy.

A. Who are you suggesting?

15 Q. Well, I understand the Canada Pensions Plan people have access?

A. That's not correct, sir. That is not correct, sir.

Q. They have no access to the file?

20 A. They would be provided with a summary of documentation, on request, and that was agreement that was reached at the request of the then-Minister of Health federally, to assist them in determining a man's entitlement to Canada Pension benefits. An agreement was reached that the Board would provide medical documentation, medical information regarding a man's condition.

But they do not have access to the Board's files.

25 Q. Maybe I used the wrong term. I guess I should say that the Canada Pensions Plan people are provided with summaries of the medical information found in Workmen's Compensation Board files?

A. That's correct, sir, on the production of a waiver from the man.

30 Q. There must be a waiver from the claimant?

A. That is correct, sir.

Q. What about the ombudsman's office?

5 A. The ombudsman is provided with a full copy of the claim file, and has been for many years, since the advent of the ombudsman, in accordance with the provisions of the Ombudsman's Act.

Q. How would it work with someone like Professor Barth?

10 A. Professor Barth completed an undertaking for the Board as a result of a request from the Commissioners that he be provided with access to the files to review and prepare his research document.

Q. I guess that Professor Weiler had access to the files as well?

15 A. I'm not aware of Professor Weiler having reviewed any claim files, sir.

Q. Or his staff. Would his staff have reviewed the files?

20 A. I think that is possible, that Professor Weiler may have requested a certain staff person to review a file, and again an undertaking would have been completed by that individual indicating that the purpose of the access was for research only.

But it was not extensive.

25 Q. So files are then made available to persons who complete an undertaking that the purpose of looking at the files is for research only? In addition to...

30 A. That's not a general thing. It related specifically to the Royal Commission, and the inquiry conducted under the provisions of...or at the request of the Ontario government by Professor Weiler, but general research policy, there would be no access to the files.

Q. Is there a policy concerning that type of access?

A. You would use the provisions that access is not provided. Section 101, if you will.

Q. Except on request of the government?

A. Well, I guess the powers of the Royal Commission permit them to have their investigators to have access to the Board's files, and there was some deliberation...as a matter of fact, there was a meeting with the Chairman of the Commission.... perhaps he would like to comment himself...requesting that his researcher be allowed access to the files because he properly felt that he couldn't do the research without that access.

Q. I'm aware of that. I'm really asking you about the Board's policy as to who else...I understand now...I mean, the Commission requested access, the Ministry of Labour, I assume, requested access for Professor Weiler or his assistants, and I'm trying to determine who else, other than the people we have identified, would be considered eligible to have access to the files.

DR. DUPRE: Just in this specific case of the Commission, Mr. Starkman, I think that you will recall that I solicited and received, in addition to access for Professor Barth, access for you, and if I recall correctly, Mr. Ublanski.

MR. STARKMAN: Yes.

DR. DUPRE: That covers the Commission's role.

MR. STARKMAN: Well, I would indicate, Mr. Chairman, that it was my position at that time that no one should have access to the files without the permission of the claimant.

I did look at certain files, but did not look at any files for which I did not have the written authorization of the claimant or the person's files that I was looking at, and I felt very strongly that nobody should look at the files who did not have such authorization.

But I think it's clear on the record what happened

5 MR. STARKMAN: (cont'd.) with respect to this Commission, and I guess what I'm trying to get at is, we know the Commission's investigator had access, and I believe that Professor Weiler's staff had access, and I'm just trying to see who else would be eligible to have access.

THE WITNESS: A. I'm not aware of anyone else having access, Mr. Starkman.

10 I don't think that you can put in the policy statement that access to a Royal Commission Inquiry would be provided. I think that flows from under their own terms of reference.

Q. That's your opinion?

A. Yes, sir.

15 Q. Now, yesterday you were talking about the appeals procedure.

A. Yes, sir.

20 Q. Do I understand that if you could start to deal with the appeal board level, when an appeal goes to the appeal board is it the administrator, an administrator of appeals sits in on the hearing, routinely?

A. Yes, sir.

Q. Does that administrator have discussions with the appeal board concerning the decision that has been made in the case?

25 A. Concerning the decision?

Q. Yes.

A. Not concerning the decision. That's the decision of the commissioners themselves, sir. He would prepare the information for them, but he would not have any role in the actual decision.

30 Q. He prepares the summary of the file, prior to the hearing?

A. Yes, sir.

5 Q. Is that the same summary that used to be provided to the claimant?

A. No, sir.

Q. In what way would it differ?

A. It's merely a documentation of the copies of the forms that he has provided to the Commissioners.

10 I would like to suggest that if you want to go into a great deal of detail regarding the appeal board procedure, that you would be best advised to have the registrar of appeals here, sir.

Q. But I understood yesterday that you said that the appeal adjudicator or administrator might write the decision?

15 A. Writes the decision at the request of the board members, yes, sir. But he has no role in the actual decision. He doesn't make the decision.

Q. That may be where we are sort of missing each other. Are we talking about someone who types the decision which is dictated by the appeals board?

20 A. The appeals board would give him instruction as to what information is to be included in the decision rendered in that case. They would indicate that they wanted reference made to some specific evidence within the case, and ask him to prepare the document for their signature.

25 In some instances I also suggested that the appeals commissioners themselves would write that decision. That's a matter of personal preference of the appeal commissioner.

Q. If a case, if a claimant is turned down at the appeal board level, do they have a subsequent right of appeal to the corporate board?

30 A. No, sir. They have a right to request a review, and they also have a right to appeal to the ombudsman.

Q. When you say review, they have a right to request

Q. (cont'd.) reconsideration?

A. Yes, sir.

Q. That is usually on the basis of new evidence that has come to light?

A. That's correct, sir.

Q. But I understand that the corporate board can overturn the appeal board?

A. The corporate board can overturn the appeal board.

Q. In what circumstances would a case...do all cases decided at the appeal board level come to the attention of the corporate board?

A. No. I am only familiar with one case having gone to the board, and I am also aware that when the ombudsman requests a review of the file, that review is carried out by the panel and then that is brought forth to the corporate board and they would advise the ombudsman of their decision following the review by the commissioners who sat on the case originally.

Q. I'm sorry. When the ombudsman requests a review, then the commissioners who sat on it originally review it?

A. That's correct.

Q. And discuss it with the corporate board?

A. They present their views to the corporate board, sir. Three of the...usually one of the members of the panel is one of the members who sat on the case, but not always. It depends on the individual.

The vice-chairman of appeals would carry that discussion to the corporate board.

Q. So under what circumstances would the corporate board overturn a decision of the appeals board?

A. Very, very rarely. I have not seen any, personally, that they have overturned the appeal board....other than the one case that I was referring to.

Q. So there is no criteria, really, for that determination?

A. No.

Q. Could you write to the WCB and ask, assuming you had lost an appeal board hearing, could you write to the WCB and ask that the corporate board consider a review of the case?

A. You could write, but I would again be looking at that panel to reconsider the decision on the basis of new evidence. I have not seen that type of case brought forward to the court before.

Q. Well, the case that did go before the board, how did it get there if that's not the regular practice?

A. I'm sorry, but I don't have the details of how the case was presented to the corporate board.

Q. But your present position is head of the claims adjudication?

A. That's correct.

Once a decision has been made by the claims review branch...

Q. Yes.

A. ...it then leaves that branch. The operating division has no further responsibility for the decision in that claim.

Any decision that is rendered subsequently is the responsibility of that department, specifically appeals.

Q. When this case went to the corporate board, weren't you secretary of the board at that time?

A. Yes, sir.

Q. So didn't it go through you, or were you aware that it was..

A. I was aware that it was being considered by the corporate board. It was brought there by the vice-chairman

A. (cont'd.) of appeals, but the process that rendered it being presented there, I was not involved in it, sir.

5 I scheduled the corporate board meetings at that point in time.

Q. You sat in on the meetings?

A. I sat in on the meeting as recording secretary. Yes, sir.

10 Q. You are not aware of any procedure which would allow, which would set out how someone would take your appeal to the corporate board?

A. There is no written procedure in that respect, sir.

15 Q. And people are not aware that they can request that the decision of the appeal board go to the corporate board? They are not informed of that?

A. No, sir. What you are looking at is the appeal board making a decision, and the request for reconsideration goes back to that appeal board. There is no formal procedure for referring the case on to the corporate board.

20 Q. What I'm looking at, you know, I'm just reading the decision of the corporate board on that matter, and it appears that...it doesn't appear to be an extraordinary process - not the way it's set out in the decision. It says that it's done, it's a reconsideration under the provisions of section seventy-five, of the decision of the appeal board, etc., etc.?

25 A. Yes.

I'm saying there is no written procedure for that procedure to take place.

30 Q. Well, I guess what I'm...I don't want to belabour it much longer, but I'm just suggesting that if it's possible for it to happen, and if it has happened, wouldn't it be advisable to notify people that this is a recourse that they have?

Q. (cont'd.) That they could take their course to the corporate board?

5 I mean, there's procedures for every other step in the appeal procedures. This is the final step in the appeal procedure and I don't quite understand why people aren't informed of that, and the guidelines or the procedures aren't set out for making that type of representation.

10 A. I would suggest that it is very, very rare that the corporate board would overturn a decision of the appeal board who has sat in on a case and has heard that case. The procedure that lies at the present time is that there is a request for reconsideration by the appeal board, and then there is a review by the ombudsman.

15 But there is no formal procedure for referring it on to the corporate board itself, present the matter to the corporate board as a result of your argument.

If you wish...that's fine.

20 Q. Now, at the appeal board level, it has been my experience that after the evidence is heard...excuse me, after the claimant presents their evidence at the appeal board level, it may not be uncommon for the appeal board to indicate that they intend...

25 A. I would suggest, Mr. Starkman, again, that you are pursuing an issue which is more properly addressed to the registrar of appeal. I do not in any way relate to the operation of the appeals area, and as secretary of the board I was not involved in the appeals area.

Q. Well, moving away from the whole question of going to the corporate board, I wanted to ask about the investigators...

30 A. Okay.

Q. ...the Board investigators.

A. Fine.

5 Q. Then, I guess what I began to say is, that after...let's deal at the appeal board level...after the claimant has presented their evidence, it may not be uncommon for the appeal board to indicate that they intend to have their investigators look into a particular area or areas?

A. Yes, I suggested that.

10 Q. Under the present policy, when the investigators have finished with their work do they send a copy of their investigation to the claimant?

A. I'm sorry, I couldn't tell you that. That information is presented to the appeal board, and again it would be a question to be addressed to the registrar of appeals.

15 Q. You are not aware of what the practice is?

A. No, I'm sorry. I'm not.

Q. That whole area of what happens after the evidence is closed at the appeal board level should be addressed to the registrar of appeals?

A. Yes, sir. That's correct.

20 Q. Who is that?

A. Mr. Farquharson, sir.

Q. Now, I had some questions...I'll move away from the whole question of the appeals procedure and reserve those for Mr. Farquharson.

25 With respect to the advisory committee that you indicated yesterday, showing us where they were found in the chart, I'm a little unclear as to how the advisory committee members are selected.

30 A. The advisory committee members are selected or appointed by the corporate board, following advice from the medical services division, and seeking information from their peers in the field of chest diseases.

Q. Do you know what their terms of service is on the advisory committee?

A. No, I'm sorry, sir, I couldn't tell you that. It would vary depending on the appointment by the Board. It's usually...no. I wouldn't like to try and qualify that answer. I just don't know.

Q. Are there any policies or guidelines the Board works with in terms of selecting the..

A. I would suggest that question would be better addressed to the medical people who advise the Board in this respect.

Q. So that would be to Dr. McCracken?

A. That's correct, sir.

Q. Yesterday we were talking about the Board having subpoena power.

A. Yes, sir.

Q. I'm just wondering if a claimant requested to subpoena Dr. Stewart to an appeal board hearing, would that request be granted?

A. No, sir.

Q. Does the Board have a policy on...

A. Again, I would suggest you address that question to the registrar of appeals, sir.

Q. You said yesterday that...I guess we are all aware that the Board doesn't publish its...it doesn't publish its decisions?

A. No, sir. That's correct.

Q. And you intimated that British Columbia, which does have policies presently of publishing its decisions hasn't been entirely satisfied with that. Could you expand on the reasons for that?

A. I have not seen a claims decision from British Columbia for some years. They have published their decisions as

5 A. (cont'd.) it relates to the change in the regulations. They have had some relating to their responsibility for occupational health and safety, they have had some relating to the adjustments for cost of living - which they are required to do under their Act, but I have not seen a claims decision from the B.C. board for some period of time.

10 Q. Do you think it would be beneficial if the Ontario Board published its claims decisions, or appeal board decisions?

A. I personally don't.

Q. Why would that be?

15 A. Because we don't go on the basis of precedent. All of the guidelines, all of the policies are there for the individuals to go by. The decision is made based on the evidence of the individual case.

Q. But I don't know if you are aware, but there are other administrative tribunals in this province. Most of them are not bound precedent, but many of them publish their decisions in order to provide...

20 A. You asked me for my personal opinion, Mr. Starkman. I provided it.

Q. So the short of it is that...

A. I don't think there would be any benefit in publishing the decision. That's my personal opinion.

Q. Because the Board is not bound by precedent?

25 A. Yes, sir.

Q. Any other reason?

A. No. I don't think there is anything to be gained by it.

30 Q. When Dr. Vingilis was here, he indicated that at times he may examine someone at Grosvenor Street...I'm not talking about the advisory committee now, but I'm talking about his capacity with the ministry...

A. I'm not familiar with his capacity in the ministry, sir.

5 Q. Yes. But when he does do those examinations, he said that they would often refer their results to the Workmen's Compensation Board. Are you aware of that happening?

A. I don't know what...

10 Q. They have discovered something about the particular person they were examining - they would refer that...

A. Oh, for the establishment of a claim?

Q. Yes.

A. Where no claim had previously been established?

Q. Yes.

15 A. I'm aware that does occur, but I'm not familiar with the procedure for it, sir. You had better address that...I'm presuming Dr. Vingilis responded to your question.

20 Like, if he is examining a man in the normal course of a review as a result of a miner's certificate or a survey program, and he identifies a condition which he feels could be related to the man's employment, then he would report that to the Board.

Q. What would the Board do when they...

A. Establish a claim, sir.

Q. It would establish a claim and send out the forms in the normal...

25 A. Yes. I think we've had three this year, as a matter of fact.

Q. From Grosvenor Street?

A. I'm saying from the ministry, and I can't tell you exactly where they flowed from, sir.

30 Q. Now, does the Board routinely get the results of the ministry's examination of the...

A. I'm sorry. I couldn't answer that question, sir.

Q. Who would be able to answer that?

A. The medical people.

5 Q. So you are not aware at all as to what information comes from the Ministry of Labour to the Workmen's Compensation Board?

A. Regarding medical examinations?

Q. Regarding medical examinations?

A. No, sir.

10 Q. What about regarding their inspections of various plants?

A. Some of their inspections are carried out at our request to obtain dust levels, sound...noise levels, that type of thing. That information comes to our claims services division.

15 Q. Okay. So the information you specifically request comes to claims?

A. Yes, sir.

Q. The examinations or the...

A. Let me say that it would come to claims through the medical, because that's where the liaison generally exists.

20 Q. So that would be another question to ask to Dr. McCracken?

A. Yes, sir.

Q. You are not aware of whether or not when the ministry does their testing not at the request of the Workmen's Compensation Board, whether those results come to the Board?

25 A. I'm not familiar with that, sir.

Q. When you make a request of the ministry to do some testing, what section are we now talking about under the Act, where that request is made? Or is it made pursuant to a section?

30 A. Just a second. I'm sorry, Mr. Starkman. I can't come up with it right off. I would have to check it and get back

A. (cont'd.) to you in that respect.

Q. Okay, thank you.

5 While we are looking at this, there are a couple of sections I would like to ask you about.

Can you look at...I believe I have the recent Act... can we look at ninety-one, four...ninety-one, subsection four?

A. Yes, sir.

10 Q. And then to me, ninety-one, subsection seven seems somehow related to it.

A. Yes, sir.

Q. I'm just wondering if you have any information as to how these sections are applied?

15 A. Section ninety-one, four was used extensively back in the early fifties. There was a fair amount of investigation that was done within the provisions of that section. There were additional assessments made arising out of that section. There was one or two Board staff who did their investigations.

20 In the early-1960's, the Board made the decision to develop the regulations relating to section then eighty-six, six, A, now currently ninety-one, seven, and you have a provision of review of the employer's records, under the provisions of that section.

25 They felt that you shouldn't be penalizing an employer under two sections at the same time. It also comes back to the experience rating program that the Board has, and when you get into that, if you have a penalty under one, you don't penalize under the other.

30 We found that under the ninety-one, four, our investigators were bumping in, if you will, to other investigators that were already on the scene, in many instances. The Board felt there was a duplication, and the best manner of proceeding was the development of section ninety-one, seven, which is the penalty clause.

5 Q. So if I understand it correctly, at the present time the Board really doesn't exercise the powers under ninety-one, four?

A. That's correct, sir. They use ninety-one, seven.

Q. Under ninety-one, seven, how is that section used? It's done by looking at the end of a year, at the accidents and the number of accidents, the costs?

10 A. That's correct, and the lifetime frequency. The lifetime accident cost records, the section is...you have the section there.

Q. Yes.

15 A. The work injury frequency, the accident cost to the employer consistently higher than the average in the industry in which he is engaged, the Board is provided by the regulation that it may increase the assessment. The first increase in the assessment is one hundred percent, and then continually up one hundred and twenty-five percent, one hundred and fifty percent, a hundred and seventy-five percent, as the employer...if he continues to fail to comply with the provisions of this section.

20 Q. Where the work injury frequency and the accident cost are consistently higher. How is that, and consistently higher, is that taken over a specified period of time, that determination whether they are consistently higher?

25 A. Over the period of a year, but then you look at the lifetime costs of the employer as well.

If you wish I can obtain for you a copy of the specific letter that is used with respect to subsection ninety-one, seven, and provide you the exact details of that.

I don't have it with me.

30 Q. I would appreciate that. It's not really for me. It's for the...if you would provide that.

A. I'll provide the information to the Commission, sir.

Q. I guess that the percentages of the increases are established there as well?

A. Yes.

Q. Then penalty?

A. Yes, sir.

Q. Can we look at section one zero one?

A. Yes, sir.

Q. Yes. I'm just wondering what the Board does about exercising its authority under Section one zero one, subsection one.

A. Well, again, I would go back to the Board primarily uses that section for the investigator or the auditor. They don't use it as, if you will, a safety section for penalties against the employer in that respect. Again, I go back to ninety-one, seven - where they use the penalty, they don't penalize in more than one instance.

You wouldn't penalize under three sections. You've got one twenty-two, which is the failure or delay in reporting. Then you've got one zero one, you've got ninety-one, seven and ninety-one, four. In each period's rating, the Board will only penalize under the one section.

Q. I guess the reason...I understand you are telling me that ninety-one, four and one zero one aren't really used by the Board because they are using ninety-one, seven.

A. That's correct, sir.

Q. But my concern is that ninety-one, four and one zero one, one seem to read as preventative sections, in my mind. In other words they are directed towards preventing access, whereas ninety-one, seven is a penalty provision, but it doesn't kick in until the actions have already occurred.

I just wondered whether the Board considered the matter in the same way that I have.

5 A. Well, I guess in part the Occupational Health and Safety Act and the advent of that Act brings the Ministry of Labour into play in the prevention. You also have the accident prevention associations, who are deeply involved in the accident prevention end. We don't use it in that respect.

Q. The Board doesn't have any staff people, inspectors or staff people, who are...

10 A. Carrying out these? No.

Q. Carrying out these roles.

A. No.

DR. DUPRE: Has this been true for a long period of time?

15 THE WITNESS: Well, as I suggested, in the early-fifties, probably up to about 1960, the Board did use ninety-one, four. But then when eighty-six and ninety-one, seven was developed, they stopped using ninety-one, four.

DR. DUPRE: Right. Now, what about one zero one, one?

20 THE WITNESS: To my knowledge it has not been used, sir, in that respect.

DR. DUPRE: It hasn't been?

THE WITNESS: No, sir.

DR. DUPRE: It has been in the Act for quite some time, I would imagine?

25 THE WITNESS: Yes, sir. It has.

MR. STARKMAN: Q. Now, if the Occupational Health and Safety Act and the inspectors pursuant to it are fulfilling some of the functions provided for in one zero one, one, I guess you are not aware of what interchanges there are between the Workmen's Compensation Board and...

30 THE WITNESS: A. Other than we fund it.

Q. Pardon?

A. Other than we fund it.

Q. Oh, I see. The Board funds...

5 A. The Occupational Health and Safety Act, to a great degree.

Q. How does that funding process take place?

10 A. I don't have the Occupational Health and Safety Act with me, but there is a provision in their Act that there is a funding of four million dollars, I think was the initial, and then it goes up ten percent every year since 1978, so the funding is now...I don't have the exact figure. You add ten percent on each year, you are up around the six million range.

15 Q. But I'm just confirming that in terms of...I understand the funding part, but the exchange of information, how does the Board become aware of what these inspectors are finding out?

20 A. Usually it would be on a request relating to a particular claim, but the information is more used by the accident prevention associations rather than the Board, because we do, as you suggest, come in after the accident.

25 But if we were looking at an employer who had a particularly bad record, we could request, if a report had been done by the Ministry of Labour, a copy of their report.

Q. You are not aware of any ongoing exchanges?

A. Not in this respect, sir. No.

30 Q. I would just like to talk briefly about the guidelines. I think we could look at the ones you provided, even though I appreciate they were prepared for the Commission.

Does the Workmen's Compensation Board have procedures for the development of these guidelines?

35 A. You were here yesterday, Mr. Starkman. I tried to give you as much detail as I could regarding the development of those guidelines.

Q. No, I understand how these guidelines were developed. What I'm asking you is whether or not...

A. I responded to that question as well, at the request of the Commission, that if it was seen by the medical services division of the claims services division that there was need to develop a guideline to assist in the adjudication in some particular type of disease, then that would be done.

Q. And is there a procedure for the updating of the guidelines?

A. The guidelines, as I suggested yesterday, are under review constantly with the development or review of any additional information that is received.

MR. STARKMAN: Those are my questions, thank you.

DR. DUPRE: Thank you, Mr. Starkman.

Mr. McCombie?

MR. MCCOMBIE: I think, if I might, I would like to defer to Miss Jolley and Mr. Laskin.

DR. DUPRE: Thank you.

Miss Jolley?

CROSS-EXAMINATION BY MISS JOLLEY

Q. I just have a few questions.

Yesterday you indicated to us in your department, the claims administrative services branch, in fact had investigators in the field that would go into work places and establish the exposure criteria. Is that correct?

A. No, that's not correct.

Q. Oh, I'm sorry. Could you tell me who exactly establishes the exposure criteria?

A. I'm sorry. I don't understand your question.

Q. When you receive an asbestos claim, a cancer claim, say, or asbestosis claim, and there is a discussion about

Q. (cont'd.) exposure, how do you get the information about exposure to determine whether or not the claim...

5 A. Well, for example, if you were using Johns-Manville, we wouldn't go into the plant. There would be a presumption of the exposure to asbestos, depending upon the occupations shown on the individual's...

Q. What about Bendix, for example?

10 A. Bendix Automotive? You would be looking at old information that was available from whatever source you could get it - interviews with the individuals - but there were no levels, to my knowledge, recorded in the old days of what the levels might have been in those areas.

15 Q. Who is it that determines, makes an estimation of the exposure?

A. Usually we would rely on the information from the Ministry of Labour inspectors in checking out the sound levels and the dust levels, as I suggested before.

20 Q. But in some of the claims that have been denied based on some of the guidelines, there have been determinations that the person didn't have ten years of continuous or repetitive exposure, and I'm wondering who makes that determination?

25 A. It would be based on all of the evidence gathered in the claim, Miss Jolley, and the information submitted by the injured worker, his representative, the employer, and any investigative work that could be done. In some of the old cases it was extremely difficult because of the lack of data, but you did have a general idea of what went on in the workplace.

Q. Do your...I guess...you mentioned the investigator, and I'm not sure what the investigator...

30 A. Okay. Yesterday we were talking about the installers, if you will, who were assigned work through the unions, who work in a transient area. Generally, the investigator would

5 A. (cont'd.) contact the individual, contact the union, and try and develop the best possible work history that he could for that individual, and it could also necessitate the need to visit employers who may be or were in existence that that employee may have been exposed with.

10 I think that Dr. Dyer will be commenting on the investigation that was carried out regarding the mesothelioma claims arising out of the gas mask manufacture during the war, in Ottawa, and he can perhaps give you a clearer indication of what investigation he did in those particular cases which might clarify the matter for you. Okay?

Q. Okay.

15 DR. DUPRE: If I could just interject a question at this point, when the term 'the investigator', or 'the investigators', is being used here, would I be able to locate 'the investigators' somewhere on the organization chart you gave us?

20 THE WITNESS: Yes. On the second chart, which is the claims administrative services branch, the top on the lefthand side - the investigative services section.

DR. DUPRE: They are in claims administration?

THE WITNESS: Yes, sir.

DR. DUPRE: Thank you.

25 MISS JOLLEY: Q. What kind of background do those investigators have? What kind of training do they have?

THE WITNESS: A. It would vary. Some of the investigators were previously claims adjudicators. Some of them worked in our counselling area. Some of them came to us from other fields, were trained in some adjudication and then put into the field because of their prior investigative knowledge. I guess we have two or three expolicemen in that respect.

30 Q. I would like to move on to...you were discussing

5 Q. (cont'd.) yesterday the fact that the appeal adjudicator might make a determination to reject a claim, in which case he would refer it directly to the appeal board?

A. No. I said that he would make a determination that he couldn't alter the decision.

Q. Right.

A. But he would not reject the claim.

Q. Right, I'm sorry.

10 A. Again, perhaps I can clarify that, because I did say that yesterday. I went back and I talked to the appeals adjudicator about it, and they advised me that it's very rare now that the claim is referred directly on to the board. In most instances the representatives are requesting an appeals adjudicator hearing before an appeal board hearing, so there would be very few of those instances.

15 Q. So if...but if he felt...oh, I see. Okay, then the next question...could I ask you about the Outreach Program that Professor Barth discussed in his study, and there is an indication that the Outreach Program was in fact disbanded. Is that correct?

20 A. No, it's still in existence. As a matter of fact, we are just currently considering visiting some additional employers that have now been identified to us as being involved in the manufacturing or utilization of asbestos products.

25 Q. Who is responsible for the Outreach Program, in the organization chart?

A. Well, it's a combination, if you will, of claims and medical. They both would visit, and as a matter of fact Mr. Ranta and Dr. Dyer were both involved in some of the visitations that took place earlier in the Outreach Program.

30 I guess it's a split responsibility, if you will, between claims and medical. We would go in and explain to the

5 A. (cont'd.) employer what our guidelines were, ask them if they could possibly identify any former employees who they might be aware of having died from a particular disease. We also approached the OFL, as a matter of fact, and some of the other unions who were involved in the utilization of asbestos products, to try and identify.

10 Q. At the time, and it is described by Professor Barth, you also sent a letter to physicians. Around 1976, there was a letter sent to...

A. Yes, asking them to have particular regard for employees' work history when they are encountering a disease.

Q. Right.

15 A. If you wish...I'm not sure...I don't know whether there is a copy of that advice still available or not, but it was a letter sent by Dr. McCracken to all of the physicians in the province.

Q. It's in fact in your brief.

20 Professor Barth, on page seven, five suggests that the program, the Outreach Program's goal blurred in midcourse, and I wonder if I could draw your attention to that middle paragraph.

He indicates:

"At first the effort was directed at publicizing the WCB's new policy of compensating for gastrointestinal cancer."

25 Then it...

A. I don't necessarily agree with his conclusion.

Q. You don't agree with that?

A. It was to try and get out in the field and identify any cases. I would suggest that it wasn't the publicity regarding the guidelines that was the issue behind it.

30 Q. So that then his criticism, his further criticism that perhaps you did not pursue that with laryngeal

Q. (cont'd.) cancer guidelines does not hold up either, then?

A. I wouldn't support it, no.

DR. DUPRE: Since there is a letter in the brief that you have submitted to us that is right on this matter, this gets us back to what Professor Barth described. Maybe we could just look at that for a moment. It's appendix eight on the very last two pages of your brief.

This is a letter over Dr. McCracken's signature to the medical profession generally...obviously right on the subject that Professor Barth is treating.

I would imagine that perhaps to the extent that he, as I think you put it, overly identifies the Outreach Program with gastrointestinal and, I guess, laryngeal cancer, perhaps he was simply led into this by the third paragraph in that letter.

Do you notice that? It was...those are basically the examples that are given there.

THE WITNESS: Well, he is talking about the bronchogenic carcinomas, gastrointestinal cancers, but I think the matter is at the top - industrially-generated diseases, and I think it could lead to some confusion in that respect. Yes.

DR. DUPRE: I guess the examples that were cited in the third paragraph of that letter may have led Professor Barth to conclude that there was ...

THE WITNESS: Because in the fifth paragraph he certainly expands on the type of exposure that he is looking for.

DR. DUPRE: Yes. Okay, thank you.

MISS JOLLEY: Q. The last question I have is, the development of the guidelines around asbestos, you have indicated to us that they really evolved out of a concern in the claims and the medical department, to about how to deal with the claims.

Q. (cont'd.) Was there any additional motivation in the fact that these guidelines evolved around 1975, 1976?

5 THE WITNESS: A. I think there were an increasing number of claims being generated at that time. I don't have the specific statistics as to how many claims occurred at what time, but when you get to the stage that you are not addressing a claim in isolation, and you see more than one, then you feel you need some, if you will, instructional guideline for the staff as to how they should generally deal with them.

As I suggested, they were developed for internal use, and as a result of subsequent requests, were published externally.

Q. Could you help us with the thought of why suddenly, in 1974, 1975, 1976, there were these increasing number of claims that even Professor Barth identified?

15 A. Well, as I suggested yesterday, the Act was amended January, 1974, to allow recognition of the disease and the payment of the benefits where the individual stayed in exposure employment, and that had not been possible prior to that time.

20 There was some reluctance, as a matter of fact, of individuals to file claims prior to that time because the provisions of the Act then, if the diagnosis was made, the benefits would be based on their earnings at the time of the diagnosis.

25 When it was changed and they continued in employment, even though their disability may have been diagnosed earlier, you then had the more current earnings on which to base the pension.

Q. Professor Barth, however, when he looked at it, suggested that the claims from Johns-Manville jumped substantially in that year, whereas perhaps some of the other claims didn't.

30 A. I would think it was because Johns-Manville was your major asbestos user, and if you look at the statistics on the

A. (cont'd.) number of claims that have been reported for the disease, the majority come out of Johns-Manville.

I don't think there was a particular trend related to that, other than the amendment to the Act and the fact that Johns-Manville was the major user.

Q. Would you maybe not also think that the fact that it was a political issue at the time, and in fact was a part...

A. I'm not a politician, Miss Jolley.

Q. But you must recognize the fact that it was in the newspapers?

A. Sure it was in the newspapers, yes.

Q. It was? You would agree?

A. Yes.

MISS JOLLEY: Thank you very much.

THE WITNESS: I can't tell you the exact date it was in the newspapers, whether it was 1975, 1976, 1974.

MISS JOLLEY: It was during the election in 1975.

THE WITNESS: But the Act was changed before the election, but not related to...

DR. DUPRE: Mr. Laskin?

MR. LASKIN: I just had a few questions that I was...

MR. EDWARDS: I think I would like to adopt your phrase and play cleanup.

DR. DUPRE: You want to play cleanup? Thank you.

MR. LASKIN: I have a few questions, just to complete my examination.

EXAMINATION-IN-CHIEF BY MR. LASKIN, CONTINUED

Q. Mr. McDonald, could I trouble you to look at schedule three, to the Statute with me for just a moment, and perhaps I could take advantage of your knowledge and experience at the Board.

5 Q. (cont'd.) I just have a couple of questions, and I see columns one and two in schedule three, and of course opposite most of the items listed in column one there is indeed a process in column two, and of course one of the exceptions to that is number eight - pneumoconioses.

Is there some historical explanation for the fact there is no process listed there?

10 A. I guess there are a fair number of pneumoconioses, that it would be...I don't know how you would describe all of the processes with the varying dusts that you've got.

As I suggested yesterday, in developing those guidelines it was done originally for silicosis, and then it was changed to mineral dust effects to recognize the many mineral dust effects.

15 Q. The Board, I take it, accepts that asbestosis is one of the pneumoconioses?

A. Asbestosis is part of the presumption of one twenty-two.

20 Q. Well, that's one of the questions I wanted to clear up with you, if I could.

See, my difficulty is that if I accept that asbestosis is a pneumoconiosis, that tells me that it is then an industrial disease. But to take advantage of the presumption, as I read section one twenty-two, subsection nine, you need something in the process column.

25 A. That's correct. But you also have to have regard for one, one N - which is: "industrial disease means any of the diseases mentioned in schedule three, and any other disease peculiar to or characteristic of a particular industrial process, trade or occupation".

30 Q. But if I'm a particular employee and I believe I've contracted asbestosis, in order to...can I take advantage of

5 Q. (cont'd.) the presumption in section one twenty-two, subsection nine, in the absence of anything in the process column? Or must I rely on the kind of broad guideline for asbestosis?

In other words, must I satisfy the Board that there has been a frank diagnosis of asbestosis, and so on?

10 A. I think that you cannot read one subsection of the section in isolation. You have to have regard for the total section, and one twenty-two, one also comes into play.

15 Then that gets you back into your definition of industrial disease.

As a matter of fact, the question is being addressed at the present time as to the absence of any process in this particular area, not as it relates to asbestosis, but as it relates to another condition, and that's one of the things we are looking at is the total application of section one twenty-two.

DR. DUPRE: The total what?

20 THE WITNESS: Application of section one twenty-two, rather than the isolation of one subsection within that section.

25 MR. LASKIN: Q. But you see, if for example, arguably speaking, if instead of item eight, pneumoconioses other than silicosis, we had in there asbestosis, and opposite it any process involving the use of asbestos, then it seems to me once a worker contracted what appeared to be pulmonary fibrosis, asbestosis, section one twenty-two, subsection nine would come to his assistance. He wouldn't have to demonstrate clear and adequate exposure to the substance. All that would be deemed in his favor, subject to someone else - presumably an employer - showing otherwise.

A. Well, as I suggested to you yesterday, I'm not familiar with any case for asbestosis having been rejected.

30 Q. I don't know whether that answers my question, but...

A. I think where the individual has worked in

A. (cont'd.) exposure to asbestos, then you still have to show that there is exposure to asbestos.

5 Q. Is what you are telling me, then, that any exposure...once he has asbestosis, however that is defined by your ACOCD or Dr. Stewart, the length of exposure is irrelevant?

A. We like to have...

Q. Generally speaking?

10 A. Yes. We like to have a history of some exposure. As I suggested to you yesterday, a man working in exposure for one day and coming down with the disease the next, I would have difficulty in accepting the claim.

Q. But you now say, in any event, this schedule is being reconsidered?

15 A. Section one twenty-two is being examined at the present time.

Q. Is that apart from whatever Professor Weiler is doing?

A. Yes, it is.

Q. Is that internally, within the Board?

20 A. Yes, it is.

Q. Is there anything that you can share with us at this stage?

A. No. The study has not yet been completed.

25 Q. One other question on schedule three. When I look at some of the other substances in schedule three, such as lead or mercury, what I see is lead - any process involving the use of lead or its preparations or compounds, and similarly when I look at mercury, the same thing.

30 I'm just wondering, again, if there is some explanation in history as to why I don't see asbestos, any process involving the use of asbestos or its preparation or compounds?

A. I'm sorry, I can't give you an answer to the

A. (cont'd.) history in that respect.

5 Q. Can I ask you whether...has the Board...that's the wrong thing.

Has schedule three been changed in recent times?

A. No.

10 Q. I guess what I'm getting at, has the Board departed from reliance on schedule three, and I take it Cabinet approved it, but has the Board really gone to the development of guidelines?

A. No. We have utilized the provisions of one, one N, which is 'peculiar to and characteristic of', in the definition of industrial disease.

15 Q. In other words, rather than have something set out in the schedule, what the Board has done internally, I take it, for a number of substances and processes, is deemed a particular disease an industrial disease under section one, one N?

A. That's correct.

20 Q. Indeed, that's what you see with mesothelioma, lung cancer?

A. Yes, sir.

Q. Asbestosis?

A. Yes, sir.

25 Q. But how far does that get you, because it seems to me then what you then do is you put on top of that exposure criteria, and latency criteria, at least for asbestos?

A. Again, I think that you have to show the disease is 'peculiar to and characteristic of'.

30 Q. But you see, can I put an example to you which might clarify the situation, at least in my mind, maybe not in anybody else's mind? Let's assume I've got asbestos in column one, and any process involving the use of asbestos or its preparation or compounds, in column two.

A. Mmm-hmm.

5 Q. And let's assume you have a worker who came from Johns-Manville at the time it was using asbestos, and let's assume that worker had lung cancer. Wouldn't you then be able to use section one twenty-two, subsection nine, to automatically presume the relationship between the lung cancer and his employment, without any further inquiry as to how long he had worked there, what was the latency period between the contracting of the disease and ...

10 A. But lung cancer is not a disease set out there.

Q. No, but it would be recognized as one of the diseases associated with asbestos.

A. But it already is.

Q. If you satisfy certain guidelines.

15 Maybe I've put the example badly. Let's assume...

A. If you have a lung cancer.

Q. Let's assume you have...

A. If you have a lung cancer in the presence of asbestosis, I think that the claim is allowed.

20 DR. DUPRE: But not because of anything in schedule three?

THE WITNESS: Because of its being an industrial disease. Not the lung cancer itself, but the asbestosis, and again, even the presence of the asbestosis is not necessary.

25 MR. LASKIN: Q. Then you are quite right in correcting me on my example. I suppose what I would have to have in column one would be lung cancer, and opposite it any process involving the use of asbestos.

A. That's right.

30 Q. And then, without any further inquiry, section one twenty-two, subsection nine would come to my assistance as a claimant, and there would be a presumption in my favor which would have to be rebutted? I wouldn't have to look at latency, exposure, so on? Isn't that putting it fairly?

5 A. Yeah, I guess it would be a way of doing it. Again, I would like to indicate, though, that I'm not familiar with all of the other jurisdictions, but Quebec, for example, will not recognize lung cancer in the absence of asbestosis, which this Board does.

10 Q. I appreciate your point, Mr. McDonald. Certainly from my brief review of comparable jurisdiction, your compensation criteria for lung cancer is much more liberal than any other jurisdiction.

15 A. But the problem that arises, in part, is that silicosis flows from exposure to silica dust. Lung cancer does not necessarily flow from exposure to asbestos. There are many other causes of lung cancer, so to put that presumption in there I'm not sure that you aren't going too far.

20 Q. Would it be a fair thing to put in asbestosis and mesothelioma into the schedule? Would those be fair additions to the schedule? Let's leave aside lung cancer for a moment.

25 A. Well, I think it's already there in practice, and I guess because of the advent of so many chemicals, you would have a continuing building of listing that would go on extensively and would be updated almost daily, if you will.

30 Q. I suppose my difficulty is, you see if I'm a claimant and I think I have mesothelioma, what I see coming from the Board is a guideline that prescribes to be automatically or virtually automatically eligible for compensation, certain criteria...and I appreciate there's a third alternative, looking at each individual case on its merits...but if I'm a claimant coming to the situation new and I see schedule three in front of me - mesothelioma in column one, asbestos operations in column two, it seems to me I'm in a different situation. I don't have to worry about...

A. I guess I haven't seen a mesothelioma claim where there was exposure to asbestos, that was rejected.

5 Q. I suppose the question that ultimately flows is, why have your guidelines? Why have you rigid exposure and latency guidelines if that is really the case?

A. You still have to have the exposure.

Q. But if you are saying that any exposure will do, why say ten years to the workers in asbestos plants?

10 A. Well, I guess having regard to the medical history or advice that was presented, you are still looking for a latency period. You are not going to get the development of the disease, and I guess I would suggest that if you are going to address the issue of latency, you had best be addressing it to medical.

15 MR. LASKIN: I cut you off, Mr. Chairman.

DR. DUPRE: No, I'm just fascinated by this.

May I ask, do you have a guideline for silicosis?

20 THE WITNESS: As set out, the presumption is in one twenty-two...one twenty-two...

DR. DUPRE: One twenty-two, nine?

MR. LASKIN: And item twelve.

DR. DUPRE: You know how slow I am, counsel. I'm just trying to learn very slowly here.

THE WITNESS: Twelve has to do with the...

25 DR. DUPRE : The answer to my question, do you have a guideline for silicosis, is no?

THE WITNESS: No.

DR. DUPRE: Is that correct?

THE WITNESS: That's correct.

30 DR. DUPRE: Now, let me see if I understand why it is that you do not have a guideline, and my understanding of why it is that you do not have a guideline is that if I read

5 DR. DUPRE: (cont'd.) one twenty-two, nine, my attention, of course, is drawn to the second column of schedule three, and where the disease contracted is the disease in the first column of the schedule, set opposite to the description of the process.

10 Now, I turn to schedule three, and I look at number twelve - silicosis - and indeed in this case I see that both columns have been filled up, one column which is called description of disease, the other column which is process.

15 Now, at this juncture what one twenty-two, nine tells me is that a claimant shall be deemed to have silicosis as due to his employment in mining or quarrying, cutting, crushing, grinding or polishing stones, or grinding or polishing material, unless the contrary is proved.

THE WITNESS: Or having regard to subsection eleven.

DR. DUPRE: Well, now, this is where I want to be very, very slow, because I'm...it's just a learning process for us.

Now, you draw our attention to subsection...

20 THE WITNESS: Eleven.

DR. DUPRE: Eleven, which reads:

"Nothing in this Act entitles an employee or his dependents to compensation, medical aid or payment of burial expenses for disability or death from silicosis, unless the employee is actually exposed to silica dust in his employment in Ontario."

25 Okay, I take that.

THE WITNESS: "For periods, in all, amounting to at least two years."

DR. DUPRE: Correct.

30 THE WITNESS: So in effect you do have a period of employment in there.

DR. DUPRE: That's a period of employment in Ontario...

THE WITNESS: That's right.

DR. DUPRE: ...for the purpose of an Ontario program.

5 Now, of course, I also note, because that may be a relatively special case, but if I go on to twelve, the Board can enter into agreements with boards in other jurisdictions, which of course might mean an altering of what is in eleven. So in other words you have an interprovincial sharing?

10 THE WITNESS: Yes. You have the last part of one twenty-two, nine, as well.

DR. DUPRE: Okay. Okay.

THE WITNESS: That's why I said you can't read this section, a subsection in isolation. You have to have regard for the whole section.

15 DR. DUPRE: And indeed, I'm trying to learn and you are helping to educate me, how to read this Act.

Now, can I put the following to you? There is something that I don't understand, at this point, about number eight in schedule three...that pneumoconioses other than silicosis... and the reason for my lack of understanding is that the way I read one twenty-two, nine you have to have both columns in schedule three filled out?

THE WITNESS: That's correct.

DR. DUPRE: For it to mean anything.

THE WITNESS: That's correct.

25 DR. DUPRE: So at this point, as a simple-minded professor of public administration, I'm looking at what is basically an idle ornament in schedule three, when I look at number eight, because it doesn't trigger anything in terms of what is after that...

THE WITNESS: In process.

30 DR. DUPRE: Is that correct?

THE WITNESS: Yes, sir.

DR. DUPRE: Okay.

Now, at this point I just want to make sure that I have run my understanding past you to make sure that I am reasonably in my tree.

With respect to all of the asbestos-related diseases, given the fact that eight in schedule three basically doesn't trigger anything in the Act, because one twenty-two, nine requires you to have both columns filled in, then with respect to all of the asbestos-related diseases the major clauses of the Act are one, one N, where it falls under the definition of industrial disease as 'any other disease peculiar to or characteristic of a particular industrial process, trade or occupation'?

THE WITNESS: Yes, sir.

DR. DUPRE: And then one twenty-two, one where an employee suffers from an industrial disease and the disease is 'due to the nature of any employment in which he was engaged'?

THE WITNESS: Yes, sir.

DR. DUPRE: Is there anything else in the Act that tells us what authority the Board has to further define industrial diseases, and the extent to which a disease is given the nature of any employment?

MR. LASKIN: I would think there is also section eleven of the regulation, at least insofar as asbestosis is concerned, which...

DR. DUPRE: Section eleven of which regulation?

MR. LASKIN: Regulation nine fifty-one.

DR. DUPRE: Regulation nine fifty-one.

MR. LASKIN: Which tells me, unless I've read it incorrectly, that asbestosis is an industrial disease. That's all it tells me.

DR. DUPRE: Well, yes. That tells me that pneumoconioses, other than silicosis, are declared to be industrial

DR. DUPRE: (cont'd.) diseases, but...

MR. LASKIN: That's as far as it goes.

5 DR. DUPRE: ...it doesn't trigger anything in terms of one twenty-two, nine.

MR. LASKIN: That's right.

DR. DUPRE: So at that point, again, I think eight is an idle ornament because, as our witness has pointed out to us, of course the Board, pursuant to certain guidelines, will recognize lung cancer as an industrial disease. Correct?

10 THE WITNESS: Yes, sir.

DR. DUPRE: GI cancer, etc., etc.

But in all of those cases in which the Board goes about its business of fleshing out the definition of industrial disease and of seeing that the condition set out in one, twenty-two one is met, there is in law...in law, as I would understand it... no rebuttable presumption in favor of the employee. Is that correct?

15 THE WITNESS: That's correct.

DR. DUPRE: Thank you for the kindergarten lesson. I really need that, Mr. McDonald, to make sure my understanding passes muster from the experts. Thank you.

20 MR. LASKIN: Q. Mr. McDonald, do you know the last time that any additions or changes were made to schedule three?

THE WITNESS: A. No, I couldn't respond to that. There was one relating to tuberculosis, which was altered a number of years ago. I can ascertain for the Commission when the last change was made, and submit that information to you, but I'm sorry, I'm not familiar.

25 Q. If the Board had the power to change, add to, delete from, schedule three, on its own without resort to Cabinet, is that, in your judgement, something the Board would welcome and utilize, or is the current method of dealing with it... 30

5 A. Oh, I don't think the Board has seen the need to amend schedule three. As I have suggested, we have used the provisions of the definition of industrial disease.

Q. Attached onto it whatever guidelines the Board has felt appropriate?

A. Yes, sir.

10 Q. Let me just ask this question, and perhaps you can give me a frank answer to it. The question is this, if you have a particular case that falls within the guidelines, meets the criteria, then I can see without much difficulty, and I take it without exception, the claim would be granted?

A. I would think that's a reasonable statement.

15 Q. If the case doesn't come with the guidelines, and I appreciate you then said you should judge every case on its merits, but do you not feel that there would be some danger that the adjudicating body, whatever it may be, would tend against granting the claim?

20 A. No. No, I feel that they do review each case having regard for the merits of the particular case. They use the guideline as a general guide, and if it's in there, yes. If it isn't, is there any other way that I can allow it. And I guess that's one thing that in my...every group of new adjudicators that come in to the Board, I meet with those adjudicators and that's one thing that I stress to them, that before you say no, do everything in your power, make every inquiry that you think that you can, to ensure that entitlement can be granted.

25 You know, that's a statement that I make to every new group of adjudicators.

30 I guess, if you will, I have drawn the comparison of the Board to an employer once the individual has an accident, and using the generic term accident, if you will, that most of the people that we are dealing with, very few of them have any

A. (cont'd.) financial backing. If they don't get their paycheque on a regular basis, they are in trouble.

5 In effect, when they have an accident, in the majority of cases they look to the Board for their paycheque.

Again, I stress to them, look, before you say no, I'm not going to give you your paycheque on Thursday and I want to hear your screams, and I try to stress that with every new adjudicator. Do everything that you can to ensure that you have made the total inquiry before you say no.

10 You can't always say yes. It just isn't there. But do everything you can before you say no.

That's, you know, I guess that's my basic philosophy as far as they are concerned. To ensure that everybody carries that out everytime, I guess it's a physical impossibility, if you will, but I certainly try to put that message across as strongly as I can.

15 Q. Fair enough.

MR. LASKIN: I think Dr. Uffen has a question.

20 DR. UFFEN: This reminds me of a problem, and this may be as good a place as any to raise it, that we've been told of, and I would like to know whether what we are told is true, but anyway, that in the case of a person who dies, the Board reviews the situation from the point of view of the widow or whoever else is...I'll use the case of a widow...and how does the widow find out that her situation has changed, that after the Board's review whether she is going to get the same pension cheque or a different pension cheque or no pension cheque?

25 THE WITNESS: When we are advised, that's the industrial disease and dependents section who receive the advice regarding the death of a pensioner, they inquire as to what was the cause of death, and usually it's a phone call...Mr. so-and-so, to the industrial disease and dependents section.

DR. UFFEN: Yes?

5 THE WITNESS: As soon as the telephone clerks receive advice that an individual has died, they would transfer the call to the industrial disease and dependents section.

One of the questions that they would ask is, what is the cause of death? What's the cause of death?

10 When they receive the claim file, in many instances they don't have the claim file at the time the telephone call is received - it's in another department, if you will, another branch, they would get the file, look at the nature of the disability for which the pension is being paid, and then they would advise the individual that either an inquiry is being made, or it would not appear that there is any relationship between the death and the
15 disability for which the pension is being paid.

DR. UFFEN: Do they advise the survivors?

THE WITNESS: Yes.

DR. UFFEN: They advise the widow?

THE WITNESS: Yes, sir.

20 DR. UFFEN: Now, I recollect something in Mr. Barth's that I may have read wrong, or I'll go back and look at it. I've got it marked here, so...yes, page three point nine of Barth, and three, eleven...ten, with the table....where it talks about the case of...on the bottom of three, nine...where a survivor makes application...that's not what I have in mind.

25 Page three, eleven in Barth says:

"The situation is in marked contrast to that where a person with an existing pension for asbestosis dies. The worker's pension is terminated, but the WCB automatically considers the question of a survivor's benefits. No
30 application need be made by a survivor."

DR. UFFEN: (cont'd.) Then he goes on:

"The problem that arises is that survivors are not aware that a very important economic decision about their future is under consideration by the WCB. They will not be able, in routine cases, to bring evidence to the WCB that may shed added light on the cause of death. Possibly more important, since they are unaware that a decision has been made by the medical services division, they are not advised of the right to appeal when the decision is adverse to them."

I won't go on any further, but they do get a letter, then, saying the pension cheques are going to stop?

THE WITNESS: Yes, sir.

DR. UFFEN: But they don't get advised...is Barth correct? They don't get advised that a study has been made of their case and that they have the right of appeal?

THE WITNESS: Again, I guess it would depend on the cause of death that is reported, but in an asbestosis claim, as I suggested to you yesterday, they would routinely conduct an inquiry as to the cause of death.

DR. UFFEN: I got that part, but I'm wondering about the widow on the other end, who is waiting. So I'll put it as a test.

Is it possible for her to first find out that her situation has changed by the discovery that she doesn't get a cheque, or that the cheque she gets is different?

THE WITNESS: Well, the cheque will automatically be different because the benefits are different in the fatal cases. Just a second.

No, it isn't here. The claims adjudicator dealing

5 THE WITNESS: (cont'd.) with that individual case, when the investigation has been completed or when the death is reported, we would advise her that we are making in inquiry to determine if there is any relationship.

DR. UFFEN: But she gets that advice?

THE WITNESS: Ray, would you...?

10 MR. RANTA: Immediately at the time of the telephone call on the death.

DR. UFFEN: So she gets a letter saying 'we are instituting an automatic inquiry into your'...?

THE WITNESS: Yes, sir.

15 Now, bear in mind that when Professor Barth was doing his review, he went back into the cases that occurred many, many years ago, in addition to current cases, and I'm not sure what reference he is making because some of the practices have changed over the number of years.

DR. UFFEN: We've had fairly recent ones, other than Mr. Barth's, where they suggested similar situations.

THE WITNESS: Well...

20 MR. RANTA: If I could add, John, a lot of times it may not be a written communication, but the widow or the caller, at the time we receive the call, is advised that inquiry will be made into the circumstances surrounding the death, and whether there is entitlement or not.

25 THE WITNESS: And that ultimate decision is communicated to the individual.

DR. UFFEN: But is she also told that she has the right of appeal?

THE WITNESS: Yes, sir. If the decision is made...

DR. UFFEN: If the decision is made...

30 THE WITNESS: No, no.

DR. UFFEN: No, no. That would be in writing?

THE WITNESS: That's right.

5 DR. UFFEN: And I gather that what Mr. Barth says on page three, eleven isn't exactly correctly correct, in your view, then?

THE WITNESS: No, sir.

10 MR. RANTA: The only explanation I could offer is that possibly his observation is, if he looked at any number of claims where the man was already in receipt of a hundred percent pension, then...

THE WITNESS: Then the death benefits are automatically...

15 MR. RANTA: ...the death benefits are automatically payable, even though for statistical purposes we review the cause of death, to see whether it was related to the condition.

DR. UFFEN: Is that letter a form letter that goes out? You must have many, many cases, of which industrial disease is a small number, and asbestos-related cases is even smaller. Is it a form letter that goes out to maybe hundreds of people, or is it a letter that is suited to the nature of the death?

20 THE WITNESS: If it's a formal denial, the letter is dictated by the individual in the review branch who would have made that consideration. The adjudicator cannot deny.

DR. UFFEN: I understand that. I'm just wondering...

THE WITNESS: No, it's not a form letter.

25 DR. UFFEN: I can't think of a better way to put it than the understanding or tenderness with which the recipient gets this...

THE WITNESS: Advice?

30 DR. UFFEN: ...added blow that not only has she lost her husband, in the example I'm using, but that her source of livelihood is gone too. I would like to see an example of such a letter, without any identification on it, and I think it's

DR. UFFEN: (cont'd.) pertinent to the point that you made a few minutes ago about trying to get through the recipients.

I would value this, because I'm not sure to what extent what I'm told by other witnesses and sources is actually true.

THE WITNESS: I'll be glad to provide that.

MR. LASKIN: Q. Could I, for just a moment, Mr. McDonald, take you to another page of Professor Barth's study, which is at chapter six, page twenty-one?

DR. DUPRE: The page again, counsel?

MR. LASKIN: Perhaps page six, twenty-two and six, twenty-three, which deals with denied claims for asbestosis and mesothelioma, and on the first full paragraph on page twenty-three of the chapter, Professor Barth does make the observation that one ought to look at the table with the caveat that some of these denied cases will perhaps ultimately be accepted.

Bearing that caveat in mind, and without...I don't, obviously, want you to go into individual details, but what kind of cases are we looking at here that are being rejected, because what I see from reading Professor Barth is that fifty-four percent of these rejected claims came from applicants who were or had been employees of Johns-Manville, for asbestosis or mesothelioma.

So what are we looking at in terms of rejection here?

THE WITNESS: A. Without being able to examine the claims and know which claims he was talking about, I would have difficulty telling you what the reason for the denial was, but again, as I suggested, I would have to question that there was a diagnosis of asbestosis. I am not familiar with any claims where there has been a diagnosis of asbestosis from Johns-Manville, having been denied. And that's fact.

So without, you know, looking at these specific claims to see what conclusion he has drawn, how he has drawn that

A. (cont'd.) conclusion, I'm sorry, I couldn't give any other response.

Nor am I familiar with any mesothelioma claim coming out of Johns-Manville, which has been denied.

Q. Just one final question on the guidelines. One observation Professor Barth makes, and it's found at page sixteen of chapter five, concerns the lung cancer guideline, and I'm looking at the last paragraph on the page where he observes it's surprising to him that apparently the recommendations of Dr. Stewart and Dr. Ritchie were not adopted by the management committee and the board, and I think he was there referring to the fact that the guidelines, as it ultimately came out, had a requirement of at least ten years occupational exposure.

Do you know of any reason why, in the translation from Dr. Stewart and Dr. Ritchie's recommendations to the Board, there seemed to be this departure?

A. I suppose it's an indication that we don't always follow the medical advice.

The board made that decision based on their review of all of the documentation that was presented to support the recommendations for the guidelines, and decided that they were satisfied with a ten year latency period.

Q. When you say the board...?

A. The corporate board.

Q. The corporate board, the six people at the top?

A. That's correct.

DR. DUPRE: Can I just ask you something about those guidelines again, because...would it or would it not be correct to say that the guidelines, a claimant within the guidelines, has a rebuttable presumption in his favour?

THE WITNESS: I would suggest yes, sir...the way the guideline is written.

5 MR. LASKIN: Q. It would not be...I don't mean to interrupt the Chairman, but I gathered from your previous answer to me that it is virtually irrebuttable?

THE WITNESS: A. Yes. It says 'will', compensation 'will' be granted.

Q. If you meet the guidelines, you get compensation, period?

10 A. That's right.

DR. DUPRE: Where does it say that?

THE WITNESS: In the preliminary to the guidelines, in the words.

DR. DUPRE: Ah, yes, but there is not statutorily-founded rebuttable presumption in favour of the employee?

15 THE WITNESS: No, sir.

DR. DUPRE: None. So this is purely an administrative rebuttable...okay.

And if that's the way you read it, there is a great deal of sense in it.

20 At this point, I guess, one of the things that I would be wondering about is, as a public administration type, what is the use of schedule three? Maybe the whole thing is now more and more an historical ornament...

THE WITNESS: Yes.

DR. DUPRE: And no wonder you are...

25 THE WITNESS: We are going away from the utilizing of schedule three, that's correct.

DR. DUPRE: Now, of course, I guess, just teasing this out in terms of the public administration aspect, the reverse case would be that if you put all your guidelines into schedule three, of course schedule three, needless to say, would become rather voluminous.

30 THE WITNESS: Well it could become rather voluminous.

THE WITNESS: (cont'd.) Yes, sir.

5 DR. DUPRE: But theoretically all of your guidelines would be available to anybody who walked into the Queen's Printer and bought a copy of the Workmen's Compensation Act?

THE WITNESS: They wouldn't know how to read it anyway, with due respect.

10 That's one of the problems. I guess that we try and put the guidelines in the simplest possible language that we can, so that it is understandable...much more so than the legislation itself, if you will.

15 DR. UFFEN: I may be getting buried in the details here, so excuse me for raising this, but I've got here a paper you brought in, one of the ones yesterday, Asbestos-Related Disabilities Resulting in Death...am I looking at the right one?

Okay? The first one deals with asbestosis, and in the guidelines for adjudication, one point one; one point two; one point three, for asbestosis, there is no mention of time at all.

20 And incidentally, it does not have typed on the bottom, 'approved by the Board, January 5, 1976'. However, as I turn the subsequent pages I find with reference to lung cancer, mesothelioma and gastrointestinal cancer, etc., specific references to dates. Each one of them says, 'approved by the Board, May 4th...', or with an appropriate date.

25 Now, is it just an accident that the one for asbestosis is different and doesn't have that typed on the bottom, or is it significant?

THE WITNESS: There was no need, I guess, in the asbestosis case, to develop the same type of guideline as what you have in the others.

30 That is very similar to the information that was provided to you on page six of our brief, and as a matter of

THE WITNESS: (cont'd.) makes the same error referring to the advisory committee of the Ministry of Labour.

5 DR. UFFEN: It's very similar, not quite the same, makes the same error, and so...

THE WITNESS: If there is no indication on there that that has been approved by the Board, then it has not been considered by the Board.

10 DR. UFFEN: This has not been approved by the Board?

THE WITNESS: No, sir.

DR. UFFEN: Now, who does this go to, besides us?

THE WITNESS: The adjudicators would have this within their policy documents.

DR. UFFEN: This is what they use?

15 THE WITNESS: Yes.

DR. UFFEN: And the basis for it is traditional usage, not identifiable Board decisions?

THE WITNESS: That's correct, sir.

DR. UFFEN: Okay.

20 DR. DUPRE: So that again is...this is something that the adjudicators have...

THE WITNESS: This document? Yes, sir. They do.

DR. DUPRE: ...as opposed to the procedures for guidelines for adjudicators, which was done for us?

25 THE WITNESS: But you will note that the same error was made from there, so they are obviously drawn from the same source, unfortunately.

MR. LASKIN: Q. Can I just ask you one question about section ninety-one, subsection seven, and I just want to make sure that I have it correctly? Mr. Starkman did ask you about it.

30 It says, "where the work injury frequency and the accident cost of the employer are consistently higher than that of the average in the industry in which he is engaged, the Board,

Q. (cont'd.) as provided by the regulations, may increase the assessment for that employer," and so on.

Does that then take me to section six of the regulation, of regulation nine...

THE WITNESS: A. It sets out the provisions that they have to meet? What page are you looking at in the Act?

Q. Page sixty-eight, Mr. McDonald, of my 1982 revision.

A. That's correct. That's contained in the letter that I mentioned I would provide the Commission.

Q. All right. Now, if an employer meets one of the subsections in section six, does that automatically mean that his assessment will be increased?

A. No. He has to meet three.

Q. All three?

A. Yes.

Q. He must satisfy, A, B and C?

A. That's correct.

Q. And if he satisfies all of those, is there then any discretion left in the Board, or must the Board then...

A. There is a discretion, but generally the Board would issue the assessment. I guess the discretion would be, are they part of a merit rating group of employers, okay? And the merit rating scheme is established on a voluntary basis by classifications of employers. I can't tell you the exact number that are in this area, but if the amount that would be assessed to the employer on the merit rating is higher than that which would be assessed under section ninety-one, seven, they would use the merit rate assessment - taking the higher of the two penalties.

So you would have regard for the classification of industry that the employer is in, before issuing the assessment.

Q. And just help me, and the merit rating provision is....?

A. Oh, section one zero five, three, if I'm not incorrect. And you can also have regard for ninety-one, six.

Q. I'm sorry?

A. It's...wait a minute now...one zero five, three is the basis for the merit rating scheme, and I can provide you with the qualifications that have to be met in order to set up the merit rating scheme. There has to be a poll of the employers within the classification. The Board, on request of an employer, trade or organization would poll the employers, and if there was a favorable response to the poll...and I can get you the provisions of the merit rating system.

Q. I appreciate that.

A. One thing that Weiler is proposing is a compulsory merit rating scheme, so that could change.

Q. Yes. And if those A, B, and C criteria are met, either you get penalty assessed under section ninety-seven, subsection one...

A. Ninety-one, seven.

Q. Ninety-one, seven, or under the merit rating?

A. That's correct. Yes.

Q. I think I just have one final question to ask you. Perhaps two final questions, and I may have covered this yesterday, but I just wanted to know what the Board's experience is in respect of employers contesting industrial disease claims before the Board. My understanding is, for example, that Bendix, as an employer, regularly contested industrial disease claims before the Board, even though it closed down its operations.

A. When you say regularly, I think there were a group of claims that came out of Bendix, and they did object to

A. (cont'd.) the allowance of those claims.

5 As I suggested yesterday, some employers make it a practice to attend every appeal board hearing. They just feel that they have a need to be there. Some employers...you notify them, but you never, ever hear from them.

10 Many employers have their own safety people who regularly make presentations at appeal board hearings, either pro or con. Some employers will support the individual in his appeal. It depends on the individual case and what their feelings are with respect to that case.

15 I wouldn't say there is any greater employer representation relating to industrial disease claims, than any other. I guess, for example, I'm not aware...and again, I haven't examined the situation...of Johns-Manville having objected to any of the industrial disease claims coming out of their company.

20 Q. I just have one final question, and it is this: Is the Board aware of, or has the Board made any inquiries, concerning the possibility of any family members of workers who obtained pensions in the asbestos field having contracted any disease? I appreciate it may not be strictly within...

25 A. I am not aware of any such inquiry having been made through the Board. And I don't...I guess for the one main reason that there would be no benefits payable in any event, under the provisions of the Act, but I'm not aware of any such inquiry having been made.

Oh, I'm sorry. Dr. Dyer?

30 DR. DYER: If I might add to this, there was one claim crossed my desk within the past two months, where when you looked at the history it would appear that this person who developed mesothelioma may have developed it as a result of a family exposure from his father, who worked for the same company a number of years

5 DR. DYER: (cont'd.) When you looked at the overall claim of the second individual - the son, that is - the claim was allowed even though the latency period was more in keeping with a family exposure than his actual work exposure.

10 THE WITNESS: There is one other claim where the individual was not employed in the asbestos industry per se. They were taking goods into an asbestos company on a regular basis, and developed mesothelioma. And that claim was allowed.

15 That was the only exposure - going in and out of that particular plant on a regular basis. But that exposure was established and the claim was accepted.

It appears you are familiar with that particular case.

15 MR. LASKIN: Yes.

Thank you very much, Mr. McDonald. You have been extremely helpful.

DR. DUPRE: Mr. Edwards, do you have any questions?

15 MR. EDWARDS: I have no questions, thank you, Mr. Chairman.

20 DR. DUPRE: Dr. Uffen?

DR. UFFEN: No.

DR. DUPRE: Dr. Mustard?

Mr. McDonald, just...

25 THE WITNESS: May I make a comment before you go on, sir?

30 I have taken you through the organization chart and I would hope you have a better appreciation for the organizational structure of the Board. I personally think it would be most helpful to the Commission if they would avail themselves of a visit to the Board's offices so that you could see where the actual process takes place, in the process of all of these claims - what occurs, how the claim flows.

5 THE WITNESS: (cont'd.) It's easy to put it down on paper, but if you see the actual process take place it might be of assistance to you, and we would certainly be available to provide you with whatever guidance is needed in that respect...for your consideration, sir.

DR. DUPRE: I welcome that invitation and we'll, of course, take it under advisement.

10 THE WITNESS: Thank you.

DR. DUPRE: My last question simply makes me want to take advantage of the experience that you have, and it is based on what Professor Weiler says on page one ten of his green book.

15 That page is in the middle of the section in which he is dealing with matters of appeal, and having described the structure he then goes on in the middle paragraph to, of course, point out the availability of the ombudsman, and then of course, the...

THE WITNESS: The select committee of the Legislature.

20 DR. DUPRE: Negotiations between the Board and the ombudsman, from time to time.

Then he gets to the select committee of the Legislature. To what select committee is he referring?

THE WITNESS: The select committee on the ombudsman.

DR. DUPRE: Ah, this is the select committee of the Legislature on the ombudsman?

25 THE WITNESS: Yes, sir.

30 DR. DUPRE: Now, can I ask you the following, on the basis of your knowledge: To the extent that that select committee... and now I'm using Weiler's words...takes it upon himself to become the penultimate court of appeal, I'm really wondering there whether Professor Weiler has used those words accurately, because as I would understand it, the Ombudsman's Act certainly does not give

DR. DUPRE: (cont'd.) a committee of the Legislature the power to overturn a Board decision, does it?

5 THE WITNESS: There has been considerable debate with respect to the power of the select committee itself. The select committee, in our opinion, does not have that power.

10 But when the report of the select committee is, if you will, adopted by the House, you are then almost in the position of having the house amend the legislation without amending the legislation, and the opinion is that oh, sure, the Board has the formal power, but to defy a...what do you call it...an order of the House, are you in contempt of the House?

It's a very moot point.

15 DR. DUPRE: So then there is very much something to what Professor Weiler is describing here then.

Let me ask you this, have there been instances where Board decisions vis a vis a claimant have ever been actually in fact and in law reversed by the select committee of the Legislature and the ombudsman, and/or the Legislature of Ontario acting on the report of the select committee?

20 THE WITNESS: The select committee publishes its report and tables the report in the House, and they make recommendations. Not all of their recommendations relating to the Board relate to individual cases. One of them related to the publication of the Board's manuals. They recommend that it be done. Now it's done, and they are sitting in the government warehouse because nobody wants them.

25 DR. DUPRE: You mean those big red books?

THE WITNESS: That's correct.

DR. DUPRE: I see.

30 THE WITNESS: There is a substantial cost to producing the documents and they are...the Ontario Government Bookstores try to give them back to us because they are faced

THE WITNESS: (cont'd.) with storing, updating and everything else.

5 Okay, some people have bought copies of the manual, that's fine. But in general, it was, okay, we've got them, now we really don't want them.

10 But that's beside the point. There were...there was one question of interpretation as far as the Act was concerned, which...to which we referred yesterday, and that was section forty-three, in which I will be providing the Commission with copies of the legal opinions...and the minister, in obtaining the opinion from the Attorney-General, supported the position of the Board and would not accede to the request of the Legislature in that respect.

15 I would have to look at...

DR. DUPRE: The minister would not accede to what?

THE WITNESS: To the request of the legislature in that respect.

DR. DUPRE: I see. Okay.

20 THE WITNESS: So what I would have to do, sir, is get the history of those cases which were presented and advise you as to the ultimate outcome of the cases. I'm not close enough to it at this point in time, and I wouldn't want to test my memory to say this happened or this didn't happen, but I would undertake to do that, sir.

DR. DUPRE: Counsel?

25 MR. LASKIN: I just wanted to remind the Commission, I know Mr. McCombie had a number of questions, and he is not here, and I do draw to the Commission's attention, and I know the witness's convenience is somewhat to worry about. I think Mr. McCombie had another commitment at five-thirty.

30 DR. DUPRE: My inclination, counsel, is for the

DR. DUPRE: (cont'd.) time being to thank Mr. McDonald most warmly for his two days with us. I will leave it to you to discuss with Mr. McCombie the extent to which his questions are questions he deems sufficiently pressing to ask of Mr. McDonald, in which case we would impose on Mr. McDonald to come back.

But in connection with those questions, of course, you may wish to remind Mr. McCombie that we have not only medical witnesses coming from the Board, but indeed the vice-chairman, Mr. Al McDonald, who may be in as good a position to answer them as Mr. John McDonald, and I do want to thank you very, very much for the day and a half that you have spent with us, sir.

THE WITNESS: I hope I have been of some assistance.

DR. DUPRE: You certainly have been. Thank you. Now, counsel, we rise until what hour tomorrow morning?

MR. LASKIN: Can I just perhaps if we have alerted to Dr. Stewart as to our starting time? Dr. Dyer, could I impose upon you to ask Dr. Stewart to be here at nine o'clock?

DR. DUPRE: Could Dr. Stewart be here at nine o'clock tomorrow morning.

DR. DYER: I will convey this message to him.

DR. DUPRE: Well, then, we rise until tomorrow at nine a.m.

THE INQUIRY ADJOURNED

THE FOREGOING WAS PREPARED
FROM THE TAPED RECORDINGS
OF THE INQUIRY PROCEEDINGS

EDWINA MACHT

